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Moving towards a recovery focused approach in a low secure forensic mental health setting: Staff perceptions and understanding of the impact of service change.

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I. Thesis Abstract

Background: Evidence suggests that the recovery focused approach provides a new conceptual framework for modern rehabilitation practice; encouraging a movement away from traditional medical treatment, towards a more person-centred, social approach to patient care. Mental health services are increasingly focused on supporting the recovery approach to patient care, with government policies continuing to encourage local teams to develop recovery focused services. In relation to the recovery focused approach, this thesis had two aims. Firstly, to systematically analyse literature which explores the impact of recovery-oriented training on staff knowledge and attitudes toward recovery practice, and secondly, to explore nursing staff perceptions and experiences concerning moving towards and using a recovery focused approach within a low secure forensic mental health setting.

Methods: Aims were addressed in two separate pieces of work. The first journal article presents a systematic review. Literature searches of six computerised databases, hand searching of selected journals, and the contacting of key authors of identified papers identified nine papers which explored the impact of recovery-oriented training programmes on increasing staff knowledge and changing attitudes towards practice. In journal article 2, interviews were conducted with eleven forensic mental health nurses in relation to service changes and analysed using Framework Analysis.

Results: The systematic review found that all nine studies demonstrated significant positive changes in mental health practitioners' self-reported recovery-based knowledge, recovery-consistent attitudes and attributions, and optimism following completion of a recovery-oriented training programme. In journal article 2, five themes were identified: managing risk; patient engagement; service developments; development of job role and ward environment.

Conclusions: The systematic review demonstrated the effectiveness of recovery-oriented training programmes at facilitating positive changes in staff knowledge, attitudes and attributions towards recovery oriented practice in clinical populations. Limitations of the papers included the relatively small sample sizes, the complex nature of the populations reviewed and the high rate of demographic confounding variables identified. The results of the original study provided insight into the views and understandings of forensic mental health nursing staff, specifically, into factors which were perceived to promote and impede the recovery focused approach within a low secure forensic mental health setting. In both articles, results are discussed in relation to clinical implications, strengths and limitations, and directions for future research.

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III. Acknowledgements

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A big thank you has to go to my academic supervisors, Dr Emily Newman and Dr Ethel Quayle. Your continuous support right from the very beginning has been much appreciated. All your helpful comments, suggestions and cups of tea and coffee, really have been fantastic. I cannot tell you both enough how much I appreciate your support and guidance during this time, be it through your upbeat positive emails or our motivational meetings, thank you both so very much!

Lastly, I want to say a huge thank you to my amazing family and friends. You have all kept me sane during this busy period, and been there for me during the best and worst parts of this project. Thank you for your continuous encouragement, support and patience. I can't wait to spend the summer with you all celebrating!

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1. Thesis Introduction

This thesis is presented in a portfolio research format as part of the Doctorate in Clinical Psychology at the University of Edinburgh. This thesis comprises of two journal articles, both of which make reference to the principles and practices of the recovery focused approach to patient mental health care.

In this context, the recovery focused approach to patient care is defined as a deeply personal, unique process of changing patients' attitudes, values, feelings, goals, skills and roles. It has been described as a way of living a satisfying, hopeful and contributing life, within the limitations caused by mental illness (Anthony, 1993). The recovery approach to mental disorder emphasises and supports an individual's potential for personal recovery, in the presence of ongoing symptoms and difficulties (NHS, 2010). According to research (Davidson, 2003; Jacobson & Greenley, 2001; Ridgway, 2001) elements of this practice include: identity formation, encouragement of autonomy and hope, the facilitation of supportive, healing relationships and enhanced role functioning (Mancini, 2008).

The recovery focused approach to mental disorder was brought to the attention of the public in the 1960s and 1970s, following deinstitutionalisation (Langan, 1990), a process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder and/or a developmental disability (Anthony, 1993). Benefits to patients following the implementation of the recovery focused approach have been observed, with evidence suggesting that encouraging patients to play a more active role in their mental health care improves long term quality, efficiency, and health outcomes for patient (Coulter & Ellins, 2007).

International health services now recommend that a recovery-oriented approach to patient care should drive service delivery (NHS, 2012). In 2005, the National Institute for Mental Health in England (NIMHE) recommended that a recovery model should guide mental health service provision and public education (NHS, 2005), with the Centre for Mental Health (NHS, 2008) aiming to put recovery at the heart of mental health services in the United Kingdom.

Within Scotland, the Scottish Executive have promoted and demonstrated support of recovery as one of its four key mental health aims and funded a specialised service, the Scottish Recovery Network to facilitate this (Scottish Recovery Network, 2013). Moreover, the 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention (Scottish Government, 2006).

Despite its growing evidence base and patient support, the recovery model has yet to make a significant impact on the working practices of the majority of mental health professionals in primary and secondary healthcare, with traditional medical approaches remaining the dominant framework (Lester & Gask, 2006). However, according to research by Lester, Tritter and Sorohan (2005), mental health patients were less likely to identify themselves as having a chronic medical illness, stating a preference for a social model of illness that emphasises recovery, in terms of their quality of life, such as returning to work and regaining family ties, and a model that acknowledges the importance of patient involvement in their own care and recovery.

The rise of the recovery movement has thus led to the development and implementation of several recovery educational training programmes for mental health practitioners. These are aimed at changing knowledge and attitudes from a traditional medical model of care to that of rehabilitation and recovery from mental health difficulties. It is now recognised globally that organisational changes towards a recovery focused approach, including staff training, environmental factors and interpersonal social climate are essential within primary and secondary healthcare services (Torrey & Wyzik, 2000). Recovery focused care of individuals with mental health difficulties requiring both recovery oriented management and staff openness to implementing recovery practices and principles (Torrey & Wyzik, 2000). According to Rickwood (2004), in order for recovery approaches to care to be implemented into clinical services, an attitude shift by service providers is required to enhance understanding of the factors that influence recovery.

Journal article one presents a systematic review which evaluated the current research regarding the impact of recovery-oriented training programmes on changing staff knowledge and attitudes towards recovery focused practice in patient care. It was of interest within the systematic review to evaluate the methodological quality of the identified studies, to summarise and interpret the impact of such training programmes on mental health

practitioners. The overarching aim of this journal article was to evaluate the impact of recovery oriented training programmes on mental health practitioners' recovery thoughts, skills and understanding. The review is formatted for submission to Clinical Psychology Review.

More specifically, forensic mental health services are increasingly focused on supporting the recovery approach to patient care (Scottish Government, 2012). Following the implementation of the Community Care Act 1990 (Scottish Government, 1990), low and medium secure forensic mental health facilities increased and high security forensic mental health settings and institutions decreased (Scottish Government, 2003). Many forensic mental health services have experienced a shift in policy and practice away from traditional long term inpatient medical care (Repper & Perkins, 2003), to that of patient recovery and rehabilitation in the community (NHS, 2006). The importance of striving towards a therapeutic recovery focused climate in secure mental health units has prompted research into the perceptions and experiences of mental health practitioners. Staff experiences of their working environment are important to the evaluation process of implementing change within a work place (Miller & Lee, 1980). Studies have provided evidence of the recovery focused approach having an effect on staff morale (Moos & Schaefer, 1987); perceptions and satisfaction (Rossberg & Friis, 2004) and changing recovery attitudes and knowledge (Gale & Marchall-Lucette, 2012; Warner, 2010). However, unlike other mental health services, including acute inpatient and community care services (Cleary, Horsfall, O'Hara-Aatons, & Hunt, 2013; Hurley & McKay, 2009; McLoughlin & Fitzpatrick, 2008), forensic mental health research has focused on the perspectives of service users, with experiences of staff relatively neglected. Few studies have explored the impact of organisational and programmatic change on the experiences of forensic mental health staff on implementing and utilising the recovery focused approach within secure forensic facilities.

Journal article two presents a qualitative study which explored the views and experiences of forensic mental health nursing staff on moving towards and using a recovery focused approach within a low secure forensic mental health service. Through semi-structured interviews, the study aimed to explore the perceptions of nursing staff on the factors that both promoted and impeded the implementation of the recovery focused approach, investigating the impact and experiences of service changes within the low secure forensic mental health service. The research study is presented as a journal article formatted

for submission to the International Journal of Forensic Mental Health, with overall conclusions, strengths and limitations, as well as recommendations for future research discussed.

2. Journal Article 1

The impact of recovery-oriented training programmes on mental health practitioners: A systematic review.

Formatted for submission to Clinical Psychology Review.

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Abstract

The recovery movement has led to the development and implementation of numerous recovery educational training programmes for mental health practitioners, aimed at increasing knowledge and changing attitudes regarding patient recovery and improvement from mental health difficulties. Despite the growing international importance of recovery-oriented attitudes, skills and knowledge amongst mental health practitioners, there is limited empirical evidence regarding the outcomes of recovery training. A systematic literature review was conducted to evaluate current international research regarding the impact of recovery-oriented training programmes on staff knowledge and attitudes towards recovery-oriented practice. Literature searches of six computerised databases, hand searching of selected journals, and contacting of key authors of identified papers was undertaken. Nine studies which met the inclusion criteria were rated according to their appropriateness to address the review aims. Both the first author and an independent second-rater evaluated the eligibility and methodological quality of the nine identified studies. The results of this review demonstrate the effectiveness of international recovery-oriented training programmes at facilitating positive changes in staff attitudes, knowledge and skills towards recovery-oriented practice in clinical populations; with themes identified in the qualitative data evident across the quantitative studies. Limitations of the review are considered and recommendations for further research are provided.

Keywords: Recovery focused approach, training program; mental health staff, systematic review.

Highlights:

- Recovery approaches to mental health care are recommended.
- We reviewed existing recovery focused training programmes.
- Recovery oriented training programmes may change staff knowledge and attitudes.

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Introduction

Recovery focused approach

Recovery from psychiatric disorders is not only possible but is likely for individuals with mental health problems (Tsai, Salyers, & Lobb, 2010). Whilst clinical recovery is possible for individuals with mental health difficulties, evidence also demonstrates that people can enter personal recovery in the presence of ongoing symptoms and difficulties (NHS, 2010).

Deinstitutionalisation in the United Kingdom in the 1960s and 1970s set out a fundamental shift from acute institutional care to a more community-based rehabilitation and recovery approach for individuals with mental health difficulties. Increasing emphasis was placed on community integration and patient involvement in their recovery (Anthony, 1993), thus resulting in the opportunity to develop recovery-oriented practices and services (NHS, 2010). Recovery is defined as a process of changing one's attitudes, values, feelings, goals, skills, and/or roles (Anthony, 1993). More specifically, in regards to mental health, recovery is described as an approach to living a satisfying and meaningful life within the limits of one's mental illness (Rethink Mental Health, 2012). Elements of the recovery focused approach include: a holistic patient-centred approach to care, the building of personal strengths and resources, and the development of effective coping strategies which encourage individuals to be actively involved in, as opposed to passive recipients of, their mental health care (Allott, Longanathan, & Fulford, 2002). Moreover, the recovery focused approach places emphasis on collaborative decision making between patient and practitioner, greater patient choice within their recovery, and greater recognition of service users as experts in their own conditions (NHS, 2010).

The recovery approach to patient care provides a new rationale for mental health services (NHS, 2010). Department of Health policies in England aimed at promoting self-management of mental health difficulties and patient choice and involvement include: 'The Expert Patient' (Department of Health, 2001b); 'Our Health, Our Care, Our Say' (Department of Health, 2006); and the 'Commissioning framework for health and well-being' (Department of Health, 2007). Rehabilitation now incorporates recovery theories and knowledge into everyday practice and patient care (Roberts, Davenport, Holloway, & Tatten, 2006). Rapp and Goscha (2006) report that rehabilitation, like recovery, primarily focuses on social, as opposed to

medical outcomes, with an increased emphasis on self-management and a 'strengths' approach, which focuses on what people can do, rather than what they cannot. The importance of maintaining hope and optimism are central to personal recovery from mental health difficulties (Perkins, Rinaldi, & Hardisty, 2008). Thus, as the foremost evidence suggests, recovery provides a new framework for rehabilitation practice, which encourages movement away from traditional medical treatment, towards a more person-centred, social approach to patient care (Department of Health, 2001a).

Lester, Tritter and Sorohan (2005) evaluated the views of patients diagnosed with schizophrenia, bipolar disorder and recurrent depression on the recovery-focused approach in a focus group qualitative study. They found that patients emphasized the importance of optimism in treatment and hope for recovery. Moreover, the study highlighted the importance that patients attach to continuity of care, listening skills and involvement in decisions made about their care, compared with specific mental health knowledge (Lester et al., 2005). Gudjonsson, Savona, Green and Terry (2011) found evidence from service users in a medium secure mental health facility, that the recovery approach to patient care improved treatment motivation, patient treatment engagement and positive social interactions. Coulter and Ellins (2007) synthesised the results of 129 systematic reviews of interventions aimed at supporting individuals with mental health difficulties to secure appropriate health care. Overall, evidence suggested that encouraging patients to be actively involved in their mental health care and treatment improved long term health outcomes for the patient themselves (Coulter & Ellins, 2007). These studies highlight the benefits patients can receive from a recovery oriented approach to care, in terms of both patient engagement and a patient centred approach to care.

Recovery training programme rationale

International health services now recommend that a recovery-oriented approach to patient care should drive service delivery (NHS, 2007). Thus, it is recognised globally that staff training is essential, with recovery-focused care of individuals with mental health difficulties requiring recovery-oriented staff attitudes, knowledge and skills (Torrey & Wyzik, 2000). In order to meet this goal, and achieve the routine application of recovery principles in mental health services, the training of service providers and practitioners is required (Uppal, Oades, Crowe, & Deane, 2008). Lester and Gask (2006) describe the importance of building on

notions of recovery and focus on using a mutually acceptable language that encompasses hope and therapeutic optimism, to further enhance mental health care.

The degree to which mental health practitioners adopt recovery principles and practice may be influenced by their subjective knowledge and attitudes regarding the prospect of patient recovery and improvement from mental health difficulties and symptoms. Hugo (2001) found mental health professionals to be less optimistic regarding prognosis for individuals diagnosed with depression and schizophrenia compared to the general public. Rickwood (2004) supports this statement by arguing that in order for recovery approaches to care to be implemented into clinical services, an attitude shift by service providers is required to enhance understanding of the factors that influence recovery. According to Bandura (1994), self-efficacy is a person's belief in their ability to succeed in a particular situation, thus determining how an individual thinks, behaves, and feels. Self-efficacy develops from mastery experiences in which goals are achieved through perseverance and overcoming obstacles (Bandura, 2007). Hahn, Binnewies, Sonnentag and Mojza (2011) found evidence of a correlation between recovery training experiences and increased recovery-related self-efficacy, sleep quality, and decreased perceived stress and negative affect. Self-efficacy, self-motivation and self-determination (Ryan & Deci, 2000) are therefore required for practitioners to accept a move away from a strict biomedical model of mental health practice towards a recovery focused approach. For this reason, attitudes of mental health practitioners are often targeted in regards to recovery, through intervention methods including, but not restricted to, recovery knowledge, models, skills and principles. This fundamental shift in attitudes, self-determination, identities and relationships can be conceptualised as a process of transformational learning (Salkeld, Wagstaff, & Tew, 2013).

Borg and Kristiansen (2004) explored the characteristics of practitioner recovery-oriented practice. They found that recovery training programmes should focus on characteristics including: openness, collaboration as equals, a focus on the individual's inner resources, reciprocity, and willingness 'to go the extra mile'. Furthermore, these authors suggested that these skills must be combined with a high level of interpersonal skills, empathy and acceptance, support for responsible risk-taking, and optimistic attitudes. Perkins and colleagues (2008) supports research collated by Borg and Kristiansen (2004), stating the need to "put 'hope-inspiring relationships' at the heart of recovery-oriented practice".

Current recovery training programmes

The recovery movement in mental health care has led to the development and implementation of numerous recovery educational programmes for mental health practitioners (Peebles, Mabe, Fenley, Buckley, Bruce, Narasimhan et al., 2009). Social learning theory focuses on learning through observation and modelling (Rendell et al., 2011). It centres on learning that occurs within a social context, where people learn from one another, and includes concepts such as observational learning, imitation, and modelling (Abbott, 2007). Recovery training delivery can vary between being delivered through didactic and interactive teaching, as well as observational, modelling and experiential learning (including, but not restricted to, role plays and case consultation tasks). An example of this is the 'thrive approach' to mental wellness (Aslan & Smith, 2007), which comprises three 1-day workshops. The 'thrive approach' to recovery training focuses on using collaborative and person centred approaches to develop self esteem, resilience and interdependence with others (Salkeld et al., 2013). The medium of delivery of the 'thrive approach' programme is heavily based on both staff and service users' narrative accounts of experiences, in order to reframe attitudes regarding future recovery. The 'Collaborative Recovery Training Program' is a 2-day recovery-training workshop which aims to change staff attitudes and reduce level of helplessness regarding recovery of patients whom they support (Oades, Lambert, & Deane, 2003). Like the 'thrive approach' programme, the 'Collaborative Recovery Training Program' also emphasizes autonomy and hope through the medium of didactic and interactive teaching (Oades et al., 2005). Results indicated a shift in recovery-supporting attitudes in clinicians who had attended the 'Collaborative Recovery Training Program', with clinicians demonstrating a greater positive, patient-centred holistic manner to the care of their patients (Oades et al., 2005).

The 'Wellness Recovery Action Planning' education programme, also known as 'WRAP', has been facilitated in the USA (Higgins et al., 2012), England (Hill, Roberts, & Igbrude, 2010), New Zealand (Doughty, Tse, Duncan, & McIntyre, 2008) and Scotland (Gordon & Cassidy, 2009). The WRAP programme duration varies from 1 day to a 20-week programme (Higgins et al., 2012), with programme content aimed at teaching mental health staff to help patients create individualised care plans including strategies for staying well and minimising distress (Cook et al., 2009). Findings by Cook and colleagues (2009) supported the WRAP intervention as an effective intervention to improve knowledge and attitudes of recovery.

Through the didactic WRAP training programme, practitioners are introduced to the recovery principles and model. In a study by Doughty and colleagues (2008), patients who had been supported by staff who had attended the WRAP education programme, reported a greater understanding of their own strengths; moreover they reported an increase in their ability to identify triggers of future mental health relapses, compared with patients supported by staff who had not attended the programme.

Project 'Georgia Recovery based Educational Approach to Treatment' (GREAT), is a further recovery oriented programme designed to educate mental health practitioners including psychiatrists and psychologists (Peebles et al., 2009). According to Peebles and colleagues (2009), the GREAT programme, unlike others mentioned, uses education techniques including role-playing, personal recovery presentations by patients, and group discussion with time allocated for question-and-answer sessions.

Systematic review rationale

Despite the growing interest and importance of recovery-oriented attitudes, skills and knowledge amongst mental health practitioners, there is limited empirical evidence for the outcomes of recovery training approaches. To date there are no systematic reviews of the literature on the impact of recovery focused training programmes on mental health practitioners. Thus, it is of interest within the current evaluation to appraise this literature, the methodological quality of the studies and summarise the impact of such training programmes on mental health practitioners. The overarching aim of this review was to evaluate the impact of recovery oriented training programmes on mental health practitioners' recovery oriented attitudes, skills and knowledge.

Method

Inclusion and Exclusion Criteria

Population

The definition of a mental health professional adopted for the use in this review was a health care practitioner who offers services for the purpose of improving individuals' mental health

or to treat mental illness (Edwards & Burnard, 2003). Populations were examined according to the following inclusion criteria:

1. Studies selected utilising adult participants (over the age of 16 years old), regardless of their ethnic background, nationality or gender, who were employed as mental health professionals and practitioners.
2. Training programmes were attended by mental health staff; that is staff employed within the disciplines including psychiatric nursing, clinical psychology, psychiatry, occupational therapy, social work, counselling and from other groups such as nursing assistants and support workers.
3. Mental health professionals working in both clinical and/or community settings were included.
4. Mental health staff employed in both the government health sector and non-government organisations were included.

Intervention

Interventions were examined according to the following inclusion and exclusion criteria:

1. Studies had to discuss training programmes or workshops in relation to the recovery approach to professional practice and patient care, including, but not restricted to, recovery models, skills, knowledge and principles.
2. The paper reported on the recovery oriented staff outcomes of the training programmes, with the location, duration and frequency of the recovery focused training being of reduced importance when selecting studies.
3. Papers which described the medium of training delivery being that of didactic and interactive teaching, as well as experiential learning (including, but not restricted to, role plays and case consultation tasks) were included in this review.
4. Both voluntary and mandatory attendances on the recovery-focused training programmes were included.
5. Studies which included training workshops that were not primarily related to the recovery focused prospects, skills, approaches and outcomes were excluded from this review.

Outcome measures

Outcome measures were examined according to the following inclusion and exclusion criteria:

1. Included studies used both quantitative measures and/or qualitative accounts of the impact of recovery oriented training.
2. Both self rated and researcher led psychometric outcomes measures were included.
3. Studies where qualitative data was of interest to the researcher, utilising semi-structured/structured interview data collection techniques were included in this systematic review.
4. Studies which did not refer to training programme impact outcomes, both qualitative and/or quantitative, or which contained insufficient data, were excluded from this review.

Study design

Study designs were examined according to the following inclusion and exclusion criteria:

1. Pre and post intervention psychometric measurement studies and/or studies including a control group were included in this review in order to facilitate comparison between conditions.
2. Controlled trials, including Randomised Control Trials (RCTs) were included, as were cross-sectional studies and cohort studies.
3. Quasi-experimental mixed-methods studies and cluster randomised quasi-experimental investigations were also included in this systematic review.
4. Single case studies were excluded due to increased potential for confounding variable bias, and due to the complexity of generalising findings.

Literature search strategy

Literature searches were conducted from September to November 2013. This process involved the searching of computerised databases, hand searching of selected journals, contacting key authors and citations in papers identified by the above searches. Due to

complications surrounding accessing translation services, only studies written in the English language were included. The Cochrane Database of Abstracts of Reviews of Effects ('DARE') contains details of systematic reviews that evaluate the effects of healthcare interventions and the delivery and organisation of health services (NHS, 2013). DARE confirmed that a similar review had not recently been conducted.

Computerised databases, including PUBMED, ISI Web of Knowledge, Psych Info, Cochrane Library, Science Direct and MEDLINE were searched. Search terms used were: "recovery"; "recovery intervention"; "Mental Health"; "Implementation"; "Training"; "Staff"; "Training Program"; "Health Services"; "Mental Health Services Training", and "evaluation".

Searching of the six databases generated 465 articles. Following de-duplication, 293 remained. Of these 293 papers, 271 were excluded following a review of the titles. On reading the full text of the articles, an additional 17 did not meet the inclusion criteria for this review (see Appendix B). Five articles meeting inclusion criteria were found through this method and were included in this systematic review (see Figure 2.1). Hand searching of the Journal of Mental Health, Journal of Psychiatry, Journal of Psychiatric Rehabilitation, Journal of Community Mental Health, Journal of Advanced Nursing and Journal of Implementation Science and citations in identified papers were conducted between and including the dates from November 2003 to November 2013. These dates were chosen to provide a ten year time frame, which is consistent with an emergence of government policies in health and social care in the United Kingdom (Department of Health, 2006; Department of Health, 2007; NICE, 2013). Two additional journal articles of relevance were found to meet the inclusion criteria for the systematic review. Finally, first authors of the seven selected articles were contacted. Four of the authors responded, with three of the key authors highlighting relevant research studies within the field of recovery. Of the eleven studies highlighted, two papers met the inclusion criteria of this review and were utilised (see Figure 2.1). In total, nine journal articles were found to meet inclusion criteria.

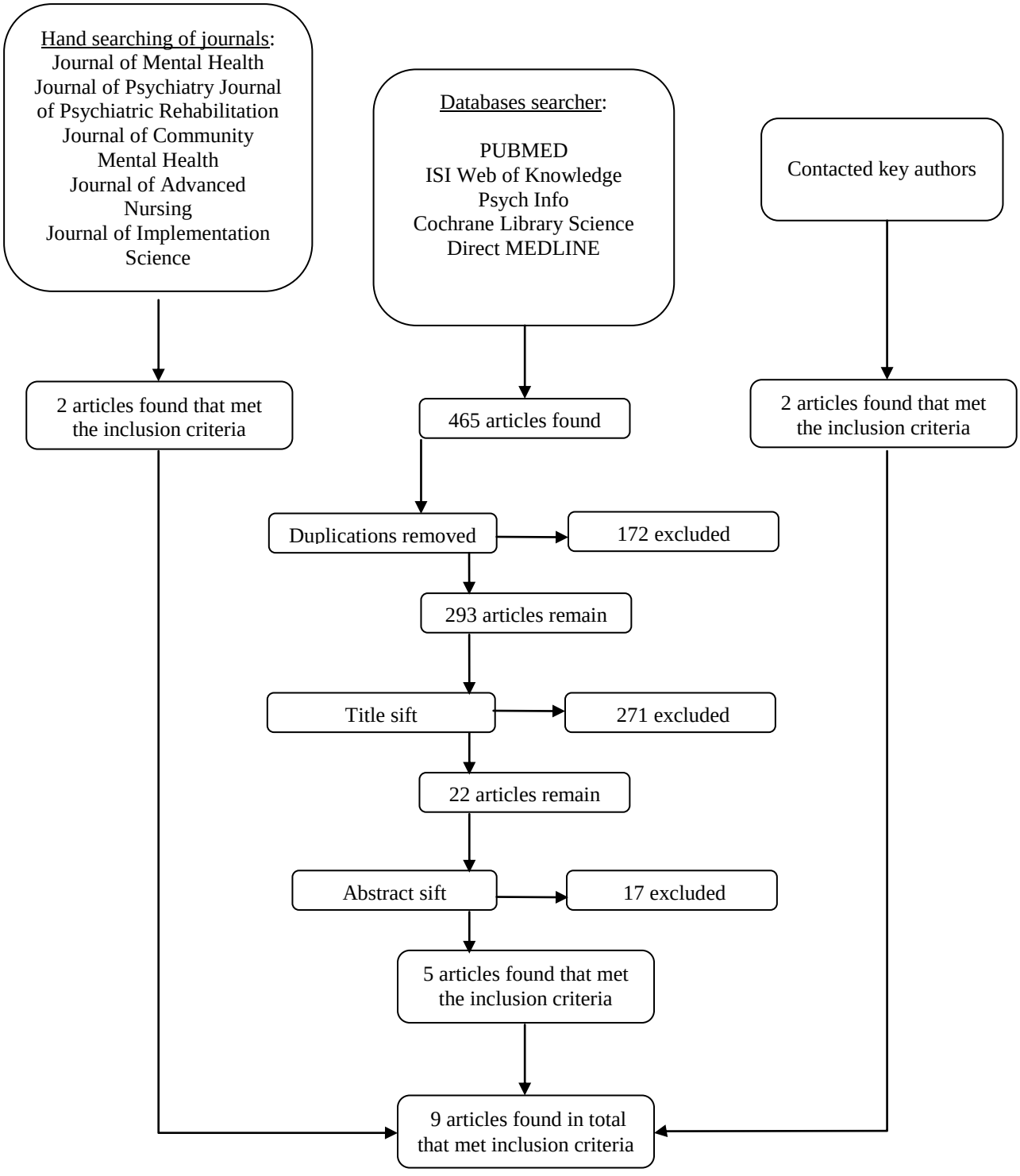

Figure 2.1 – Flow chart illustrating the journal articles search process.

Criteria for Methodological Quality Appraisal Assessment

Studies were rated according to their appropriateness to address the aims of this systematic review. Quality assessment tools were developed for the purpose of this review following consultation of the British National Critical Appraisal Skills Programme collaboration (CASP, 2010), the Scottish Intercollegiate Guidelines Network (SIGN, 2011) and the National Institute of Health and Care Excellence (NICE, 2013). Clinical practice guidelines have been defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (SIGN, 2011). The process of critical appraisal involves systematically examining research to review its reliability, validity and relevance within a particular context (CASP, 2006).

Studies which met the inclusion criteria used quantitative outcome measures and/or qualitative reporting of the impact of recovery oriented training; hence CASP, SIGN and NICE quality criteria guidelines were consulted in regards to the methodological areas of quantitative, qualitative and mixed methods research to ensure relevant aspects of quality were measured. Three separate methodological quality assessment tools were developed to critique qualitative (18 items), quantitative (22 items) and mixed method studies (25 items) selected for this review. See Appendix C, D and E for the full tables of qualitative, mixed method and quantitative criteria. Criteria was rated and scored accordingly: Well Covered (++) =3, Adequately Addressed (+) =2, Poorly Addressed (−) =1, Not Reported (NR) =0 and Not Applicable (NA) =0. For each article cited, a total score and percentage was calculated to determine the strength of quality.

In order to certify the inter-rater reliability of the rating scale, 5 papers were independently selected and reviewed by a second rater using the same quality criteria rating tools. The inter-rater reliability quotient was high, with a Kappa co-efficient for overall agreement of 0.75, signifying good overall inter-rater agreement (Randolph, 2008). This suggests that the quality assessment tool of the selected studies within this systematic review was clear and replicable. Any discrepancies in ratings were reviewed and discussed, and in all cases an overall score was thus resolved and agreed by both reviewers.

Results

Characteristics of included studies

Table 2.1 summarises the nine studies which met the inclusion criteria. One study utilised a qualitative methodological design study (Salkeld et al., 2013). Six studies were experimental studies which used quantitative outcome measures (Crowe, Deane, Oades, Caputi, & Morland, 2006; Gudjonsson, Webster, & Green, 2010; Peebles et al., 2009; Tsai et al., 2010; Salgado et al., 2010; Tsai, Salyers, & McGuire, 2011). Two studies were of mixed-methods design (Gilbert, Slade, Bird, Oduola, & Criag, 2013; Higgins et al., 2012).

Due to the methodological diversity of the included studies, a narrative synthesis of the study findings is presented. Data extracted from the nine studies included: study design, sample size and characteristics, intervention, outcome measures, summary of the main findings and data-base from which it was identified.

Table 2.1 – summary of included studies

Author, year & country	Study design	Participants (number, male/female)	Intervention	Outcome measures	Summary of main findings	Database
Crowe et al (2006) Australia	Experimental design (quantitative methodology) Pre/post measures completed. Absence of control group.	248 Mental health workers (41% non-gov/59% gov health workers) (74 male/174 female)	2 day recovery based programme	RAQ-7, collaborative recovery knowledge scale & STARS	Following the programme, increased knowledge regarding recovery, collaboration between staff and patient, enhanced motivation, and assessment of patients subjective needs and goals. Increase level of hopefulness and beliefs regarding ability of individuals to set/achieve goals. Desired changes found in knowledge, beliefs and attitudes related to recovery.	PsycINFO
Gudjonsson et al (2010) UK	RCT (quantitative methodology) Presence of control group.	137 Mental health workers in medium secure forensic unit (71 male/64 female)	1 day recovery approach training – didactic and experience approach (handbook given)	Recovery approach staff questionnaire	Those who attending training found positive attitude about the recovery approach to care and its implications in forensic services. Increased knowledge, facilitated hope and opportunities and sense of control for services users in staff who attended training.	Medline
Gilburt et al (2013)	RCT quasi-experiment mixed	190 Mental health workers in community	4 day workshop and an in-term ½	Audit of care plans at baseline and 3	Training programme had positive change on the content of patient care plans and the	Science Direct

UK	methods (qualitative & quantitative methodology) Presence of control group.	and rehabilitation teams. Audit of 700 case files (400 from staff who did training/300 who did not) 16 interviews	day session of supporting recovery (mandatory)	months post-training Semi-structured interviews at 3 months post training	attributed responsibility for the actions detailed. Interviews identified positive changes in staff approaches to patient care/practice, with greater consideration of holistic input, increased knowledge and increase use of recovery-related terminology.	
Salkeld et al (2013) UK	Experimental design (qualitative design) Absence of a control group.	10 mental health workers & 7 services users did workshops (only 4 staff interviewed)	3 x 1 day workshops using concepts from the THRIVE approach to recovery/mental wellness.	Semi-structured interviews	Recovery training that involves both staff and service users whom they work with can decrease discrimination and power differentials. Positive impact on working relations and respective self identities, facilitating positive changes in attitudes and practice of staff towards holistic approach and appreciation of individuals' goals.	Web of Knowledge
Peebles et al (2009) USA	RCT (quantitative methodology). Control group.	34 Mental health workers (17 male/17 female)	3 hr workshop – overview of recovery movement 2 hr workshop – shifting attitudes (1 month later)	Project GREAT recovery knowledge measure, RKI, recovery attitudinal pre-post survey, attribution questionnaire	Workshops were successful in enhancing attitudes and knowledge of the recovery model and principles.	Hand searching Journal of Community Mental Health (23/10/13)
Tsai et al (2010) USA	RCT observational study (quantitative methodology) Pre/post measures completed. Presence of a control group.	184 hospital mental health workers (54 male/130 female)	3 day recovery oriented workshop (some completed specific/practical skills interactive workshop, some attended general/inspirational training and some received no training)	LOT-R, consumer optimism & RSA	Staff who received specific/practical skills training had more positive recovery attitudes and beliefs and made more effort to help patients achieve their goals, than those who received general/inspirational training or no training. Training better than no training in terms of knowledge and attitudes.	Web of Knowledge
Salgado et al (2010) Australia	Experimental design (quantitative methodology) Pre/post measures completed. Absence of a control group.	75 Mental health workers (gov & non-gov organisations) (26 male/49 female)	2 day training in recovery concepts and skills	RAQ-7, STARS, HS, TOS & RKI.	Regardless of dispositional hope (level of personal dispositional hope did not improve recovery), improvements in understanding and attitudes of consumer recovery prospects after intervention. Improvements in knowledge, and changes in attitudes, hopelessness and optimism	Contacted first authors

					regarding recovery.	
Tsai et al (2011) USA	RCT (quantitative methodology) Presence of a control group.	318 community mental health workers (95 male/223 female)	2-day 'illness management and recovery' training & 1-day case consultation workshop	LOT-R, consumer optimism scale, recovery self assessment	Staff who received recovery training had higher consumer optimism and reported greater agency attention to consumer life goals. Training positively related to staff knowledge and attitudes towards consumer and aspects of their organisation.	Contacted first authors.
Higgins et al (2011) Ireland	Mixed methods design (quantitative & qualitative methodology) Pre/post measures completed.	197 mental health practitioners & carers completed 2-day training (68 male/126 female). 67 completed 5-day training (20 male/38 female). 33 completed focus groups.	2-day 'Recovery Action Planning Education Programme'. Subsequent 5-day programme for smaller cohort.	RKQ, RAQ-7, Beliefs about Recovery Questionnaire & WRAP questionnaire. Focus groups.	Staff who received systematic education and training in recovery principles reported positive changes in perceived recovery skills, knowledge and attitudes.	Hand search of Journal of Advanced Nursing (01/12/13).

RAQ-7 – Recovery Attitudes Questionnaire (Borkin et al., 2000).
STARS – Staff Attitudes to Recovery Scale (Snyder et al., 1991).
RKI – Recovery Knowledge Inventory (Bedregal et al., 2006)
RKQ – Recovery Knowledge Questionnaire (National Institute of Mental Health UK, 2007)
LOT-R – Personal Optimism Questionnaire (Beck et al., 1985)
RSA – Recovery Self Assessment (O'Connell et al., 2005)
TOS – Therapeutic Optimism Scale (Byrne et al., 2006)
HS – Dispositional Hope Scale (Snyder et al., 1991).

Summary of results – the impact of recovery oriented training programmes on mental health practitioners in clinical and community settings

Quantitative design studies

Crowe et al. (2006) and Salgado et al. (2010) utilised pre and post-training programme psychometric assessment measures; however, unlike the other four quantitative studies identified in this review (Gudjonsson et al., 2010, Peebles et al., 2009, Tsai et al., 2010, Tsai et al., 2011) they did not utilise a control group in their study design. Crowe et al. (2006) described the outcome of 248 government and non-government mental health community workers following a two-day recovery-based training programme, with outcomes measured on the Recovery Attitudes Questionnaire (RAQ-7) and the Staff Attitudes to Recovery Scale

(STARS). Following completion of the programme, staff demonstrated significantly higher levels of hope and beliefs regarding individuals with mental health problems to set and achieve their own goals. Desired changes in mental health staff's knowledge, beliefs and attitudes related to recovery were found across all factors on the RAQ-7, STARS and collaborative recovery knowledge scale being higher post-training, reflecting a positive shift towards the recovery focused approach to patient care. Recovery knowledge regarding principles of recovery, including techniques of goal setting, motivation enhancement, needs assessment and patient autonomy were found to increase post-training.

Salgado et al. (2010) implemented a 2-day skills and concepts education-based intervention programme called the Collaborative Recovery Training Program. This was used with a group of government and non-government mental health practitioners, with the aim of positively changing recovery knowledge, attitudes, hopefulness and optimism following training. The following assessment tools were used to measure to changes in recovery knowledge and attitudes: the Recovery Attitudes Questionnaire (RAQ), the Dispositional Hope Scale (HS), the Staff Attitudes to Recovery Scale (STARS), the Therapeutic Optimism Scale (TOS) and Recovery Knowledge Inventory (RKI). Significant increases across all subscale scores were evident when comparing pre and post-training data; specifically, positive changes were evident in terms of mental health staff recovery knowledge, attitudes, hopefulness and optimism. They found that regardless of individual levels of dispositional hope prior to training, mental health staff demonstrated similar positive changes in their understanding and attitudes regarding patients' recovery prospects. Regardless of the disparities in training models and methods of the programmes, findings by Crowe et al. (2006) and Salgado et al. (2010) are similar; indicating positive changes in self-reported recovery-based knowledge, attitudes and hopefulness following completion of a recovery-oriented training programme, all of which reached statistical significance in comparison to pre-training psychometric measures.

Gudjonsson et al. (2010) described the attitudes of forensic mental health practitioners following participation on a 1-day training package on the forensic recovery approach to care. On the Recovery Approach Staff Questionnaire, a significant difference was found between forensic mental health staff that had completed the training compared with those that had not. Staff members who had attended the training were found to be more positive in their attitudes towards the recovery focused approach to patient care. Moreover, staff who had completed

the training reported a greater knowledge and understanding of the recovery model, believing that recovery does not mean being symptom free for the patient. In addition, there was a difference between groups in terms of certainty in the recovery approach being an effective methodology for patient care. Ninety-six percent of mental health staff who had attended the recovery training programme reported greater belief that the recovery approach was an effective approach to patient care compared to the control group. However, they also found evidence that those that had attended the training reported greater uncertainty compared to those that had not received training in relation to whether or not applying the recovery approach meant patients would be discharged more rapidly into the community.

Peebles et al. (2009) described results from an education-based intervention programme called Georgia Recovery based Educational Approach to Treatment, known as project GREAT. This was used with a group of mental health practitioners and consisted of an initial 3 hour workshop centred on the recovery movement principles and practice, followed by a 2 hour workshop a month later which centred on shifting attitudes. The aim of project GREAT was to increase knowledge regarding recovery in mental health staff, and demonstrate a change in attitudes following the second workshop towards a recovery focused approach to patient care. Educational techniques included role-playing, patient presentations regarding own experiences, and group discussions with time allocated for question-and-answer sessions. Utilising the assessment tools: the Recovery Knowledge Inventory; the Project GREAT Recovery Knowledge Measure (RKI); Recovery Attitudinal Pre-Post Survey, and the Attribution Questionnaire (AQ-27), elevations and positive changes across all subscales of recovery-based knowledge, recovery-consistent attitudes and attributions, including affective responses and roles and responsibilities in recovery were significantly increased compared to those that did not receive the intervention and training. This provides evidence of the positive changes in recovery knowledge, attitudes and attributions following attendance of the training programme.

Tsai and colleagues (2010) described a 3-day recovery focused training workshop for 184 hospital mental health professionals. At baseline and 1 year following completion of the programme, mental health practitioners completed self-report questionnaires, including the Personal Optimism Scale (LOT-R), Consumer Optimism Scale and the Recovery Self-Assessment (RSA), which measured their subjective optimism, patient optimism and agency recovery orientation. Staff were randomly assigned to different training programmes,

categorised into general/inspirational, specific/practical recovery training or they received no recovery training. It was hypothesised that specific/practical skills training would have a greater positive impact on recovery attitudes compared to general/inspirational training or no recovery-oriented training. Results were consistent with this hypothesis; at 1-year post training, staff who received specific/practical skills training reported a greater change in recovery attitudes and efforts to support client's pursuit of goals, and overall greater positive changes in recovery attitudes and beliefs than those who received general/inspirational training or no training. Specific/practical skills training was found to be the most effective recovery focused training technique, with the overall findings suggesting that recovery-oriented training was better than no training in terms of increased recovery-based knowledge and positive changes in recovery-consistent attitudes; moreover in terms of personal optimism, patient optimism and agency recovery orientation.

Tsai and colleagues (2011) explored personal optimism, patient optimism and agency recovery orientation in a sample of 318 community mental health practitioners, utilising the Personal Optimism Scale (LOT-R), Consumer Optimism Scale and the Recovery Self-Assessment assessment tools, following a 2-day intervention programme called illness management and recovery, aimed at helping staff to acquire skills and knowledge in order to partner with patients to set and achieve goals. Like the studies by Gudjonsson et al. (2010), Peebles et al. (2009) and Tsai et al. (2010), findings showed that at a one-year follow up, mental health staff who had attended the recovery-oriented training programme scored significantly higher on the measures than mental health staff who did not attend the programme. Mental health staff who had received the training reported significantly higher personal optimism, consumer optimism and a greater agency orientation towards patient goals, with these results being consistent with results from Tsai et al. (2010) previous research the previous year.

Mixed methods design studies

Through a mixed methods study design, Higgins and colleagues (2011) showed that a Wellness Recovery Action Planning education programme led to significant positive changes toward recovery, in the skills, knowledge and attitudes of practitioners and family members/carers of those with mental health difficulties. Pre and post-test measures, the Recovery Knowledge Questionnaire (RKQ), Recovery Attitudes Questionnaire 7 (RAQ-7),

Beliefs about Recovery and WRAP questionnaire completed over a year's time frame, plus focus group interviews revealed that the positive impact of the programme on participants' attitudes and beliefs about recovery. Furthermore, qualitative data indicated that this education programme, which advocated recovery approaches to patient care through education in recovery methodology, appeared to inspire, invigorate and empower both mental health professionals and carers. Delivery of the programme was in two stages: with all participants completing a 2-day programme regarding recovery principles, followed by a smaller cohort subsequently attending a further 5-day programme. Quantitative data collated through questionnaire completion following the 2-day training programme found a statistically significant elevation when comparing pre and post measures, with a significant difference found in recovery oriented positive beliefs, knowledge and attitudes. However, a ceiling effect was evident for mental health staff that completed the subsequent 5-day training programme, suggesting that five additional training days did not have any value over the first two days. Findings from focus group data furthermore suggested that involvement of practitioners and family members/carers of those with mental health problems within recovery education training programmes, increased partnership skills and positively changed recovery attitudes and beliefs.

Gilburt and colleagues (2013) described outcomes from a quasi-experimental mixed methods study, which evaluated the perceived impact of recovery-oriented training on mental health practitioners. An audit of care plans was undertaken at baseline and three-months post-training. A random sample of 700 care plans (400 intervention, 300 control) were audited, with each action point coded according to a pre-determined list of categories. With regards to implementation of recovery-oriented practice, care plans of patients in the intervention group had evidence of changes in the contents, with decision-making being attributed to both patients and staff collaboratively, rather than attributed solely to staff, compared with those in the care of a control group. Through semi-structured interviews with staff that had completed the training programme, a positive impact was reported in terms of recovery approaches to patient care and practice, including a greater involvement of holistic care provisions, a move from maintenance to mental health improvement, and utilisation of new 'recovery-oriented' terminology. In addition, mental health staff who had completed the recovery training programme reported increased recovery practice, knowledge and approaches compared to the control group. However, half of the interviewed staff, described the training having little or no impact on their recovery beliefs and knowledge.

Qualitative design study

Salkeld and colleagues (2013) explored the impact of a recovery-oriented training programme on mental health staff, when the training was delivered jointly to staff and service users. Qualitative measures in the form of semi-structured interviews were only completed with the mental health practitioners. Thematic analysis of the interviews demonstrated that educational recovery training facilitated positive changes in staff attitudes, knowledge and practice regarding recovery, towards a more holistic appreciation of people's concerns and goals. Staff reported positive changes in working relationships and professional identities. Similar to findings stated previously by Higgins et al. (2011), Salkeld et al.'s (2013) findings suggested that a model of recovery training can be transformative for both mental health staff and their patients. Positive outcomes were described in terms of joint learning between staff and service users, facilitating a sense of trust and openness that supported the recovery learning experience. Conducting the qualitative research six months following training completion highlights that these changes in staff attitudes, knowledge and practice towards a recovery approach to patient care are sustainable, at least in the short term.

Summary across all studies

Although the nine selected studies differ in terms of training methods and models underpinning the interventions, population demographics and follow up periods, overall the findings are similar across all of the selected studies. All of the studies selected for this systematic review demonstrated positive changes in self-reported recovery-based knowledge, recovery-consistent attitudes and attributions, and optimism following completion of a recovery-oriented training programme. The factors within each intervention programme which facilitated positive changes in recovery knowledge and attitudes are not demonstrated by these findings. The longevity of such changes following training programmes are demonstrated at one year post-intervention in three studies (Higgins et al., 2011; Tsai et al., 2010; Tsai et al., 2011) and at a 6 month stage post-intervention in one study (Salkeld et al., 2013), otherwise the long term impact of recovery-oriented training on mental health staff is not demonstrated by these studies. Moreover, confounding variables, including previous training received by mental health practitioners, are not taken into consideration in any of the identified studies included in this systematic review. Hence, this presents a difficulty when generalising results from this review across future mental health services.

Quality of included studies

Table 2.2 provides a summary of the methodological strengths of the six quantitative studies selected for this systematic review. Table 2.3 provides a summary of the methodological strengths of the two mixed method studies and the one qualitative study selected for this systematic review. Quality rating scores of the included studies ranged from 79% to 89%, suggesting that overall the selected papers were of a high quality. Within this systematic review, the mixed methods study by Higgins et al. (2011) and the quantitative outcomes study by Peebles et al. (2009) are suggested to have the highest methodological strength with ratings of 89% quality. Consistent areas of weakness across the studies included the absence of reporting of meaningful follow-up time of subjects, the lack of clear and coherent reporting of ethics and the description of the role of the researcher. Consistent areas of strength across the studies included the appropriateness of the analytical approach and research design, outcome and analysis relevance and reliability, and the discussion of limitations and study implications for future practice.

Table 2.2 - methodological assessment of the six quantitative studies

Quality Criteria	**Included Studies**					
	Crowe et al. (2006)	Gudjonsson et al. (2010)	Peebles et al. (2009)	Tsai et al. (2010)	Salgado et al. (2010)	Tsai et al. (2011)
Is a quantitative approach appropriate?	++	++	++	++	++	++
Was there a clear statement of the aims of the research?	++	++	++	++	++	++
Was the research design appropriate to address the aims of the research?	++	++	++	++	++	++
Is the source population or source area well described?	++	++	++	++	++	++
Is the eligible population or area representative of the source population or area?	++	++	++	++	++	++
Were outcome measures reliable?	++	++	++	++	++	++
Were all outcome measurements complete?	++	++	++	++	++	++
Were all important outcomes assessed?	++	++	++	++	++	++
Were outcomes relevant?	++	++	++	++	++	++

Was the follow up of subjects complete enough?	NA	++	++	++	NA	NA
Was follow-up time of subjects meaningful?	NR	NR	NR	NR	NR	NR
What are the results of this study?	++	++	++	++	++	++
Was the study sufficiently powered to detect an intervention effect (if one exists)?	NR	NR	NR	NR	NR	NR
Were the analytical methods appropriate?	++	++	++	++	++	++
Was the precision of intervention effects given or calculable? Were they meaningful?	++	++	++	++	++	++
Are the study results internally valid (i.e. unbiased)?	++	++	++	++	++	++
Are the findings generalisable to the source population (i.e. externally valid)?	++	++	++	−	++	++
Do the results of this study fit with other available evidence?	++	++	++	++	++	++
What are the implications of this study for practice?	++	++	+	−	++	++
Is there adequate discussion of any limitations encountered?	−	++	++	+	++	++
How clear and coherent is the reporting of ethics?	NR	−	++	NR	NR	NR
As far as can be ascertained from the paper, how well was the study conducted?	++	++	++	++	++	++
Total score (%)	52 (79%)	58 (88%)	59 (89%)	52 (79%)	54 (82%)	54 (82%)

Table 2.3 - methodological assessment of the two mixed methods studies and the one qualitative study

Quality Criteria	**Included Mixed Methods Studies**		**Included Qualitative Study**
	Gilburt et al. (2013)	Higgins et al. (2011)	Salkeld et al. (2013)
Was a mixed-method approach appropriate?	++	++	NA
Was a qualitative approach appropriate?	NA	NA	++
Was there a clear statement of the aims of the research?	++	++	++
Was the research design appropriate to address the aims of the research?	++	++	++
Was the source population or source area well described?	+	+	NA
Was the eligible population or area representative of the source population or area?	+	+	NA
Was the role of the researcher clearly described?	NR	NR	NR
Was the context clearly described?	++	++	++

Were the methods reliable?	++	++	+
Were outcome measures reliable?	+	++	NA
How well was the data collection carried out? Were all outcome measurements complete?	++	++	++
Were all important outcomes assessed?	++	++	NA
Were outcomes relevant and reliable?	+	++	NA
Was the follow up of subjects complete enough?	++	++	NA
Was follow-up time of subjects meaningful?	−	++	NA
Was there a clear statement of findings?	++	++	++
Was the study sufficiently powered to detect an intervention effect (if one exists)?	NR	NR	NA
Was the data analysis sufficiently rigorous?	NA	NA	++
Was the data 'rich'?	NA	NA	++
Were the analytical methods appropriate? Was the analysis reliable?	−	++	+
Was the precision of intervention effects given or calculable? Were they meaningful?	+	++	NA
Are the study results internally valid (i.e. unbiased)?	++	++	NA
Are the findings generalisable to the source population (i.e. externally valid)?	++	++	+
Do the results of this study fit with other available evidence?	++	++	++
What are the implications of this study for practice?	++	++	++
Was there adequate discussion of any limitations encountered?	++	++	+
How clear and coherent were the reporting of ethics?	++	++	+
As far as can be ascertained from the paper, how well was the study conducted?	++	++	++
Total score (%)	64 (85%)	67 (89%)	46 (85%)

++ - Well Covered
+ - Adequately Addressed
− - Poorly Addressed
NR – Not Reported
NA – Not Applicable

Discussion

Synthesis of findings

The results of the systematic review found that all nine studies demonstrated significant positive changes in mental health practitioners following completion of a recovery-oriented training programme. A high level of similarity in findings was found between the qualitative study and the qualitative data from the mixed methods studies. Qualitative themes of self reported positive attitudes towards the recovery approach and perceived positive impact on practice were consistent across the qualitative study and the qualitative data from the mixed

methods studies. In both the mixed methods studies and the qualitative study, methodology and data collection were rated as being well covered, with all interviewed staff verbally reporting positive changes in their recovery knowledge, perceived skills and attitudes following training. Within this systematic review, qualitative data represented a third of the studies, with the majority of studies being quantitative in nature. Themes identified in the qualitative data are evident across the quantitative studies, with subjective descriptions of the impact of the training programmes being consistent with psychometric outcome measures. Hence qualitative data collated supports and furthermore justifies quantitative results obtained. Five studies included a control group (Gudjonsson et al., 2010, Gilburt et al., 2013, Peebles et al., 2009, Tsai et al., 2010, Tsai et al., 2011) and found significant differences between those who had and had not attended the intervention. Hence, within these studies, positive change in staff knowledge and attitudes towards recovery oriented practice can be attributed to the recovery-oriented training programmes. Three studies referred to pre and post programme outcomes (Crowe et al., 2006, Salgado et al., 2010, Higgins et al., 2011), demonstrating significant differences prior to, and following attendance of a recovery-oriented training programme in regards to positive changes in staff recovery attitudes, knowledge and hopefulness. In the one qualitative study (Salkeld et al., 2013), mental health practitioners disclosed that the educational recovery training they had attended, had facilitated changes in attitudes, knowledge and practice regarding recovery, towards a more holistic appreciation of people's concerns and goals. Overall, the available evidence collated from these selected quantitative, qualitative and mixed methods studies strongly suggests that recovery-focused training programmes are of relevance in facilitating positive change in mental health staff knowledge, attitudes and beliefs regarding recovery oriented practice in the care and support of patients. These findings are consistent with health service policy which states the benefits of training programmes in adopting a recovery oriented approach to patient care (NHS, 2007). With differing methodological techniques utilised in the measurement and assessment of practitioners' recovery-oriented approach to patient care, comparisons across the nine studies are difficult. Thus, suggestions for future research recommend the agreement of core outcome measures for recovery-oriented training to allow for direct comparisons between different programmes.

The longevity of the impact of recover-oriented training programmes on staff recovery knowledge, attitudes and beliefs are demonstrated at one-year post-intervention follow-up in three studies (Higgins et al., 2011,Tsai et al., 2010, Tsai et al., 2011) and at a six month post-

intervention follow-up in one study (Salkeld et al., 2013). However, the longitudinal impact of recovery-oriented training on mental health staff was not demonstrated in five of the selected studies (Crowe et al., 2006, Gidjonsson et al., 2010, Gilburt et al., 2013, Peebles et al., 2009, Salgado et al., 2010). In two studies (Higgins et al., 2011, Salkeld et al., 2013) evidence emerged regarding the involvement of service users and/or carers within recovery education training programmes, with positive outcomes described in terms of enhancing partnership skills and facilitating a sense of trust and openness that supported the recovery learning experience. Joint learning between staff and service users could further improve and facilitate positive outcomes in terms of staff recovery knowledge, attitudes and beliefs, and clearly indicates the need for further research.

Strengths and limitations of the review

A number of limitations should be taken into account when considering the results of this systematic review. Research in regards to recovery oriented training and education programmes was overall limited within this field. Only published research and studies written in the English language were included within this review, hence other research may have been overlooked. The authors attempted to overcome such limitations by communicating with authors of included studies; however no unpublished research was identified. A further potential weakness of this review is the subjective bias in regards to the assessment of the quality criteria for each of the selected study. This limitation was addressed by the presence of a second marker, with a high inter-rater reliability found. However, both raters were psychologists by profession; hence this could, possibly, be a further source of bias when categorising referral information, due to both raters having similar educational histories and professional training.

Finally, it is important to note that the primary interest within this review was mental health staff outcomes following the attendance of a recovery oriented training programmes, with the location, duration and frequency of the training programmes being of reduced significance when selecting studies. Methodology in the delivery of such training programmes was not consistent across the studies, hence the heterogeneous nature of the studies included in this review is considered to be a limitation, with the diversity of the recovery programmes potentially limiting the conclusions which can be drawn from this review.

Strengths and limitations of the papers

The nine studies selected for this systematic literature review reflect recovery training implementation practices from across the world, including studies conducted in the United Kingdom, United States of America, Australia and Ireland. One of the strengths of the papers within this review is that the results can be related to current international mental health practices and policies, with all papers providing up to date empirical evidence from the last decade in support of recovery oriented training programmes.

A number of limitations of the papers selected for this systematic review are acknowledged. Firstly, it is apparent that many of the studies relied on relatively small sample sizes. Moreover, none of the six quantitative studies included in this review addressed the question of statistical power, used in empirical studies to calculate the minimum effect size that is likely to be detected in a study using a given sample (Parks, 2010). Hence, the absence of power analysis in all of the quantitative studies; moreover the small research populations, may well have restricted the extent to which conclusions can be drawn from this data and generalised to other mental health practitioner populations.

A second limitation is the complex nature of the populations reviewed and the high rate of demographic confounding variables identified, including number of years employed within mental health services, prior exposure to recovery information, and previous recovery-oriented training received. For example, it is possible that mental health practitioners with previous recovery training and/or exposure to recovery information are more biased towards the recovery approach to patient care, hence emerging differences between groups may not entirely reflecting the effects of training. In the five studies that utilised the presence of a control group (Gudjonsson et al., 2010, Gilburt et al., 2013, Peebles et al., 2009, Tsai et al., 2010, Tsai et al., 2011), significant between-group differences were consistently evident. However, confounding variables such as previous training and exposure to recovery material, limits the ability to identify differences between the training groups and no training groups, reducing data validity, reliability and generalisability to the wider populations of mental health clinicians. Future research within this field should consistently utilise pre and post training measures to compare individual responses and levels of change.

Thirdly, the longevity effects of the recover-oriented training programmes on staff recovery knowledge, attitudes and beliefs are not reported in five of the studies within this review. Knowledge gains and changes in attitudes do not necessarily translate into enduring change in practice (Peebles et al., 2009). Therefore, knowledge of the longitudinal impact of training on mental health staff is of importance and requires further research attention, with increased awareness of the longitudinal effects of training having benefits in terms of individual and service economic costs.

Other limitations identified are the use of convenience samples, and the self-report nature of evaluating the impact of the training programmes. These limitations have the potential to cause bias in the collated data, including a potential for social desirability effects, which reduces data validity, reliability and generalisability to the wider populations of mental health clinicians.

Future research

Methodology in the delivery of recovery oriented training programmes were not consistent across the studies, with training programmes varying in location, frequency and duration, therefore the heterogeneous nature of the studies included in this review was considered to be a limitation. Hence, future research recommendations are made to evaluate the impact of the quantity of recovery oriented training on recovery knowledge and attitudes in mental health staff. The quantity of training may be of future importance. According to Swarbrick (2006), the more recovery trainings staff attended, the higher their recovery scores on personal and consumer optimism. Moreover, the type of training, such as whether having peer education or experimental exercises, or utilising the involvement of service users and/or carers are of interest, to help identify the factors that cause changes in staff attitudes and beliefs. Thus, it is the recommendation of the primary author that further research be conducted in regards to the analysis of the factors which directly contribute to changing recovery knowledge, attitudes and beliefs in staff. Gaining insight into the specific factors of the recovery oriented training programme that directly facilitate positive changes in participants recovery knowledge, attitudes and beliefs is of significant interest to future clinical practice when organising the implementation of future recovery training workshops, specifically in terms of the time management and economic cost.

Moreover, suggestions for future research include the agreement of core outcome measures to facilitate direct comparisons between studies. The utilisation of pre and post training measures are recommended for all future studies within this field of research, in order to compare individual responses and levels of change, moreover to reduce the bias caused by individual differences. Furthermore, research regarding the long term effects of the impact of recovery training programmes is of future interest to the primary researcher, with recommendations suggested regarding the incorporation of longer follow up periods to examine the longitudinal effects of such training programmes. Gaining knowledge into the longitudinal effects of recovery training workshops would provide mental health services with data regarding re-training timescales and number of workshops per annum, hence having economic benefits at an organisational level.

Finally, further studies are recommended to explore which positive changes in staff recovery beliefs and attitudes are implemented and encouraged at an organisational and management level, and whether practitioner changes result in direct causal changes in patient outcomes and clinical practice. Future research directions could measure the strength of correlation between practitioner recovery knowledge, attitude outcomes and behaviour changes following completion of the recovery oriented training programme and service user recovery processes.

Implications for clinical practice

This systematic review provides evidence of the effectiveness of recovery-oriented training programmes at facilitating positive change in mental health practitioner's recovery knowledge, attitudes and beliefs regarding patient care and support, at least in the short term. This systematic literature review has implications for research, practice and policy. Results collated from the nine studies within this review are consistent with current government policies and recommendations, that a recovery-oriented approach to patient care should drive service delivery (NHS, 2007). Given the importance of a recovery-focused approach to patient care, there is a need for recovery training principles and methods to be embedded into routine service delivery and mandatory staff training. Moreover, it is recommended that recovery-oriented training should be incorporated into the earlier stages of training to ensure longitudinal effects and consistency across future practice. It is predicted that the incorporation of recovery-oriented training into university and college educational student

programme for mental health practitioners, including nursing, psychology, psychiatry, social work and occupational therapy, would overcome future barriers such as staff turnover in mental health services and organisational economic costs of training/retraining those joining services. Moreover, in providing consultation and supervision for practitioners following recovery training, Clinical Psychology Services could contribute to sustaining and prolonging service based programmatic and organisational changes, consequently reducing the economic costs of retraining. Through therapeutic processes such as mentalization-based therapy (Fonagy & Bateman, 2008) and motivational interviewing (Miller & Rollnick, 1991), support for practitioner reflection, regarding their experiences of training and implementing changes, could continue recovery practice post-training through the maintenance of self-efficacy and self-determination.

There is a need for these studies highlighted in this review to be replicated on a larger scale, for example across clinical settings, so that results can reflect a broader clinical and/or community mental health population.

According to Higgins et al. (2010), implementation of recovery focused practice requires not only training initiatives, but a fundamental change in culture within organisations to overcome the traditional biomedical approach, shifting away from the present preoccupation with illness to one of wellness. Hence, in regard to service recovery outcomes at an organisational level, further studies are recommended to examine the full extent to which positive recovery attitudes and beliefs are implemented and supported at an organisational level, and whether practitioner changes in recovery knowledge and attitudes result in direct changes in patient outcomes and clinical practice. Extending recovery training programmes to wider staff, management, carers and to the service users themselves may be one method of encouraging a recovery focused approach to patient care at an organisational level.

Conclusion

The results of this review demonstrate the effectiveness of recovery-oriented training programmes at facilitating positive changes in mental health staff knowledge and attitudes towards recovery oriented practice in clinical populations. These results are consistent with research within this field in recent years, with further research warranted to further investigate what elements of the training are related to positive changes, and how staff

recovery knowledge, attitudes and skills through training programmes can further contribute to patient care.

References for Journal Article 1

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3. Journal Article 2

Moving towards a recovery focused approach in a low secure forensic mental health setting: Staff perceptions and understanding of the impact of service change.

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Abstract

The importance of staff roles in implementing the recovery approach has prompted research into staff experiences. Qualitative interviews explored the views of eleven nurses on implementing a recovery approach within a low secure forensic mental health service, with data analysed using Framework Analysis. Ten participants described a belief in the value of recovery principles and positive experiences utilising the approach. Five themes were identified: managing risk; patient engagement; service developments; job role developments and ward environment. Results highlight implications for service policy and practice, providing new information regarding barriers and constraints associated with service changes and adopting a recovery approach.

Keywords: forensic mental health; recovery focused approach; nurses; qualitative.

Word Count: 9182 (excluding abstract, references and appendices)

Introduction

Since the Community Care Act 1990 (Scottish Government, 1990), which gave rise to a more community-based approach to care for individuals with mental health difficulties, the United Kingdom has seen rapid changes in the nature of service provision for mental health patients. 'Delivery for Health' (Scottish Executive, 2006) set out a fundamental shift in the National Health Service (NHS), from acute, institutional care to one that is community based. Hence, long-term psychiatric institutions were subsequently closed, with mental health services undergoing organisational and programmatic changes towards a recovery focused approach to patient care.

Recovery-Focused Approach to Care

According to the National Review of Mental Health Nursing in Scotland (NHS, 2009), previous mental health nursing practice focused on patient illness and risk aversion. There was a lack of choice in alternative treatments to pharmacological therapies for individuals with mental health difficulties (NHS, 2012). However, the concept that people can and do recover from severe mental illness has become more accepted in recent years (Rethink Mental Illness, 2012). According to the Scottish Recovery Network (2004), recovery is defined as being able to live a meaningful and fulfilling life in the presence or absence of symptoms. Previous treatment models have been based on reactive care; however, the recovery focused approach focuses on prevention, through early individualised intervention (NHS, 2012). Preventative care includes aspects such as building a positive relationship with staff (Repper & Perkins, 2003), family and friends and supporting an individual to feel empowerment and control over their minds and lives (Anthony, 1993). The

Mental Health (Care and Treatment) (Scotland) Act 2003 supports and promotes recovery for long-term mental health problems (Scottish Government, 2003). Health care practitioners and service-users are now seen as collaborative partners in an individual's recovery process and social re-integration (NHS, 2012).

Impact of Organisational and Programmatic Changes

Organisational and programmatic changes impact both patients and practitioners (Wanberg & Banas, 2000). Much research has been conducted in regards to patient recovery-oriented perceptions and satisfaction (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), and treatment outcome (Melle et al., 1996); however only a few studies have explored the impact of organisational and programmatic changes on the experiences of mental health practitioners, in terms of implementing and utilising the recovery focused approach within their work environment. In mental health services, the experiences of professionals are central to the programmatic acceptance and implementation of the recovery process (Lysaker & Buck, 2008). Behavioural and cognitive motivation is essential for an acceptance of the recovery focused approach (Marchall-Lucette, 2012). Self-efficacy, self-motivation and self-determination (Ryan & Deci, 2000) are required for practitioners to accept a change from a biomedical model of mental health practice towards a recovery approach. Knowledge depends on an individual's internal drive and self-determination to understand and promote the learning process (Vygotsky, 1978), with self-efficacy developed from mastery experiences in which goals are achieved (Bandura, 2007). In terms of Maslow's Hierarchy of Needs model (Maslow, 1954), esteem needs, cognitive needs and self-actualisation needs are pertinent to the acceptance and implementation of the recovery process, with knowledge, self-fulfilment, self-esteem and personal development of mental health practitioners being

fundamental to the recovery approach to patient care (Anthony, 1993). Hence, research in mental health services has been conducted to explore the experiences of practitioners regarding this approach, gaining insight into perceived advantages and disadvantages.

Cleary, Horsfall, O'Hara-Aatons and Hunt (2013) utilised thematic analysis to analyse interviews with twenty-one mental health nurses on recovery-focused topics in an acute inpatient mental health unit in Australia. Nurses reflected positive experiences regarding the recovery approach, with person-centred care and individualised approaches to care plans viewed as positive programmatic changes. Hurley and McKay (2009) conducted semi-structured interviews with eight occupational therapists regarding their views on implementing recovery principles in an acute psychiatric hospital in Ireland. Thematic analysis revealed that the occupational therapists viewed the impact of change as minimal, stating their practice was already patient centred prior to organisational and programmatic changes. They described the perceived barriers as staff reluctance and lack of openness to change and the ineffective use of resources. Staff reflected that for recovery practice to be a success, commitment was needed by all staff. Piat, Sabetti and Bloom (2010) supported this finding: interviews conducted with managers of a mental health facility in Canada revealed that an organisational shift to a recovery approach must include active leadership from decision makers and commitment from all practitioners working with service-users. Warner (2010) found evidence to suggest that empowerment was an important moderating component of organisational and programmatic change, stating that staff optimism facilitated recovery practice. This study supports earlier research by Rebeiro-Grulh (2008) who stated that positive and optimistic staff attitudes regarding recovery were essential for the implementation of the approach; whist negative staff attitudes and low motivation were barriers to recovery.

McLoughlin and Fitzpatrick (2008) explored the recovery attitudes of mental health nurses in state mental health institutes. Utilising the Recovery Self Assessment-Registered Nurse Version (RSA-RN), positive perceptions of the approach's impact were evident in older and more experienced nurses, those who had received formal recovery training or education, and those who considered their facilities to be recovery-oriented. Gale and Marchall-Lucette (2012) administered self-efficacy questionnaires to twenty-three community mental health nurses to investigate recovery-oriented practice. Findings revealed a difference in nurses' perceived ability and confidence in recovery-oriented practice. These studies furthermore support the concept that recovery attitudes and knowledge differ across nursing staff and impact the level of approach acceptance and application; thus this is an area for future investigation.

These studies demonstrate the impact of organisational and programmatic changes on mental health staff, and highlight the importance of practitioners' experiences of implementing and utilising the recovery focused approach, to gain insight into the perceived promoting and impeding elements of the practice. Moreover, these studies provide evidence of the approach being implemented to some degree by mental health services and staff, and supports the view that recovery oriented-practice does have a place within mental health facilities; however, generalisation of these results could be limited due to methodological and research issues. Staff awareness of the research aims, the self-report nature and the use of closed questions in the assessment measures increase the risk of biased and socially desirable responses, which contribute to difficulties in data interpretation and may reduce data reliability and validity.

Changes to Forensic Services

In the context of forensic populations, forensic mental health facilities have experienced changes in service provision for patients (Rutherford & Duggan, 2007), with a movement away from containment to recovery (Scottish Government, 2006). For example, in Scotland, there has been a significant reduction in high secure facilities and an increase in medium and low secure forensic units (Drennan & Alred, 2012), giving rise to a community-based approach rather than containment (Crichton, 2009). Forensic mental health services are increasingly trying to be more focused on supporting and implementing programmatic changes towards a recovery approach to patient care (Lammie, Harrison, MacMahon, & Knifton, 2010), with Government policies continuing to encourage local teams to develop recovery oriented services (Scottish Government, 2006). Gudjonsson, Webster and Green (2010) investigated the experiences of mental health staff in a forensic mental health service. Results indicated that the majority of staff agreed that the recovery approach had a positive impact on their practice and attitudes regarding patient recovery and rehabilitation into the community; specifically they reflected on the additional involvement of the multidisciplinary team as having a positive influence.

Current Study Rationale and Aims

Unlike other mental health services, including acute inpatient and community care services, forensic mental health research has focused on the perspectives of service users, with experiences of staff relatively neglected. Mental health nurses represent the largest paid workforce of people working directly with forensic mental health patients, and play a key role in implementing recovery focused changes (NHS, 2012). The rationale for this research

was to explore the impact of organisational and programmatic changes on the experiences of nursing staff in a low secure forensic setting; to understand how participants described and made sense of these changes and the impact these changes had on them, the patients and their relationships. According to Smith and Firth (2011), a qualitative approach is appropriate when exploring complexities surrounding subjective knowledge and perceptions, and can facilitate an in-depth understanding of a participant's experience. Hence, qualitative methodology was proposed within this exploratory study. The principal objective was to ascertain the views of nursing staff on moving towards and using a recovery focused approach within a low secure forensic mental health setting. Secondary questions were: what is the impact and experiences of nursing staff of service changes on themselves; what do nursing staff feel promotes the approach and what may impede the recovery focused approach?

Method

Ethics

The research was given ethical approval from local NHS ethics and NHS Research and Development Management (Appendix G). All research activities complied with the ethics research process at the University of Edinburgh, BPS code of ethics and conduct, and Good Clinical Practice guidelines.

Participants

Inclusion criteria for the study were that participants were forensic mental health nursing staff who had been employed for a minimum of six months before service changes were implemented on the ward and were currently employed in the same unit. Participants had to be over the age of eighteen years. Twenty-three members of the nursing staff were eligible to participate within the current study. Eleven people (five male and six female) who met the criteria agreed to take part in the study.

Procedure

Those members of nursing staff who met the inclusion criteria were invited to attend a meeting where information about the present study was provided by the principal researcher. Staff members who wished to participate were invited to contact the researcher by telephone or email. The first author arranged to meet individually with potential participants to provide them with written participant information (see Appendix H) and to ensure that they were fully aware of the right to refuse to answer questions and to withdraw at any point during the interview process. Written consent was obtained for each participant prior to conducting the interviews (see Appendix I). Interviews were conducted individually during working hours and lasted approximately one hour (length of interview ranged from 24 minutes to 72 minutes).

Interview questions were open ended and based on a schedule, focusing on the impact of service changes on perceptions and experiences of using a recovery approach and what had facilitated and hindered this approach. Full debriefing of the research study was provided

following the interview. Interviews were digitally recorded and transcribed verbatim for subsequent analysis. Participant identifiable information was removed on transcription, using pseudonyms where appropriate. All identifiable data were securely stored according to NHS protocols.

Analysis strategy

Anonymised digital data were analysed by a principal researcher using Framework Analysis (Ritchie & Lewis, 2003). Framework method was chosen for a number of reasons. First, it provides a systematic model for managing and mapping themes and is suitable for cross sectional, interview data and research that has specific questions, a limited time frame, a pre-designed sample and a priori issues (Srivastava & Thomson, 2009; Gale, Heath, Cameron, Rashid, & Redwood, 2013; Lewis & Ritchie, 2003). The interconnected stages in the Framework Analysis explicitly describe the analysis process (Smith & Frith, 2011), therefore aiding researchers in this process. Finally, unlike thematic analysis, Framework Analysis is tied to, or stems from, theoretical frameworks where individual experiences and perceptions are investigated (Braun & Clarke, 2006), while exploring associations and explanations in the data and drawing on existing theories and established literature (Smith & Firth, 2011). Framework Analysis has been used in similar forensic studies (Judge, Quayle, O'Rourke, Russell, & Darjee, 2012).

In Framework Analysis, data are sifted, charted and arranged according to key themes, with five distinct stages of data management and familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation adopted to form a methodical framework for data analysis (Srivastava & Thomson, 2009). These stages

facilitate the data to be explored in greater depth while simultaneously maintaining an effective and transparent audit trail (Furber, 2010), thus increasing the rigour of the analytical processes and data reliability (Ritchie & Lewis, 2003). Researchers can move forwards and backwards across these stages until coherent themes emerges (Smith & Firth, 2011). Each stage of analysis will now be described.

For data management and familiarisation, three transcripts were read and re-read by the lead researcher to become familiar with the contents and to gain insights into the topics discussed. Reoccurring topics were identified across the three interview transcripts. Further reading led to the identification of initial themes and categories, including: managing risk; patient engagement; attitudes to the service; development of job role, and structured environment. A list was generated of these themes, and this represented the initial index framework identified at this stage (Appendix J). With constant referral back to the raw data, the initial index framework allowed for themes to be highlighted across other transcripts. This initial framework remained flexible, to allow for additional themes to be added. Next, the indexing framework was applied to each sentence, phrase or paragraph of all eleven interview transcripts. This process involved the highlighting of key phrases and comments written in the margins to record preliminary thoughts. Key phrases were summarised using nursing staff members' own words. Throughout this process, the indexing framework was revised and edited to incorporate new topics which had previously not been identified.

Through further analysis of the data, initial themes were developed into more formal ideas, from which a thematic chart, also known as a coding matrix, was generated using Microsoft Office Excel. The coding matrix included the main themes identified and line numbers of key words and extracts to summarise the content for each participant within each

theme sub-topic. Index categories were represented in a row, with each participant represented by a separate column (see Appendix K, L, and M). This presentation facilitated the management of a large amount of data; moreover it allowed for comparisons to be made across the participants' transcripts. Reviewing data in this manner also highlighted which themes remained true to the raw data, with this being a fundamental principle in the Framework Approach and vital when developing abstract concepts (Smith & Frith, 2011).

The final stage of the Framework Analysis methodology was to summarise and synthesise the range and diversity of coded data through descriptive accounts, by refining initial themes and categories (Smith & Frith, 2011). Core concepts were explored in relation to pre-existing literature and theoretical perspectives relating to service changes in the low secure forensic mental health service (Smith & Frith, 2011). The final matrix of data (Appendix N) enabled the researcher to gain insight into how links were formed between codes and categories, and between categories and themes (Ritchie & Lewis, 2003). In addition to descriptive written accounts and explanations of themes and analysis results, data were also displayed in a diagram to visually represent the key themes and inter-relations (see Figure 3.1). Displaying data in this manner aided researchers to understand, analyse and communicate to others the themes and patterns which had emerged throughout the analysis process (Miles & Huberman, 1994; Ritchie & Lewis, 2003).

Quality assurance

Framework Analysis is a qualitative technique that is open to researcher bias when identifying emergent themes (Howell, 1992). To overcome this risk, the principal researcher conducting the framework data analysis demonstrated awareness and fully acknowledged her

role in undertaking data interpretation (Smith & Frith, 2011). The researcher aimed to carry out analysis in a transparent and reflexive manner to ensure that the processes followed were clear and considered (Lewis & Ritchie, 2003; Yardley, 2008). Moreover, the researcher adopted the five distinct steps to form a methodical and rigorous framework for data analysis (Srivastava & Thomson, 2009). Data coded from the semi-structured interviews were checked and re-checked by the principal researcher at several points during the analysis stage of the study, to provide alternative perspectives of the emergent framework themes and reduce subjective researcher bias (Lewis & Ritchie, 2003).

In order to ensure the process from raw data to emergent themes was reliable and valid; an independent second researcher familiar with the implementation of Framework Analysis methodology independently selected and reviewed three transcripts. Unlike the principal researcher, the second rater had limited knowledge regarding the recovery focused approach, and of the changes that had occurred within the low secures forensic mental health service. There were high levels of agreement in both emergent themes and categories, indicating good overall inter-rater theme agreement (Randolph, 2008). Discussion was carried out around the data, including emerging themes, potential refinements and development of data, to ensure consistency and coherence throughout the analysis process (Yardley, 2008). Any discrepancies in themes were reviewed and discussed, and in all cases overall themes and categories was agreed by both reviewers, hence ensuring a reduced bias in the identification of emergent themes.

Results

The initial themes were consistent across the eleven interviews with forensic mental health nurses and resulted in five themes being identified. These included: ward environment; service development; development of job role; managing risk, and patient engagement. Overall, ten out of eleven participants were in support of the recovery focused approach. The majority of participants reported believing in the value of the approach, however described some constraints in implementing these organisational and programmatic changes. Figure 3.1 visually represents the main themes and their sub-topics. In the following section, each key theme is described and illustrated by extracts from the interviews.

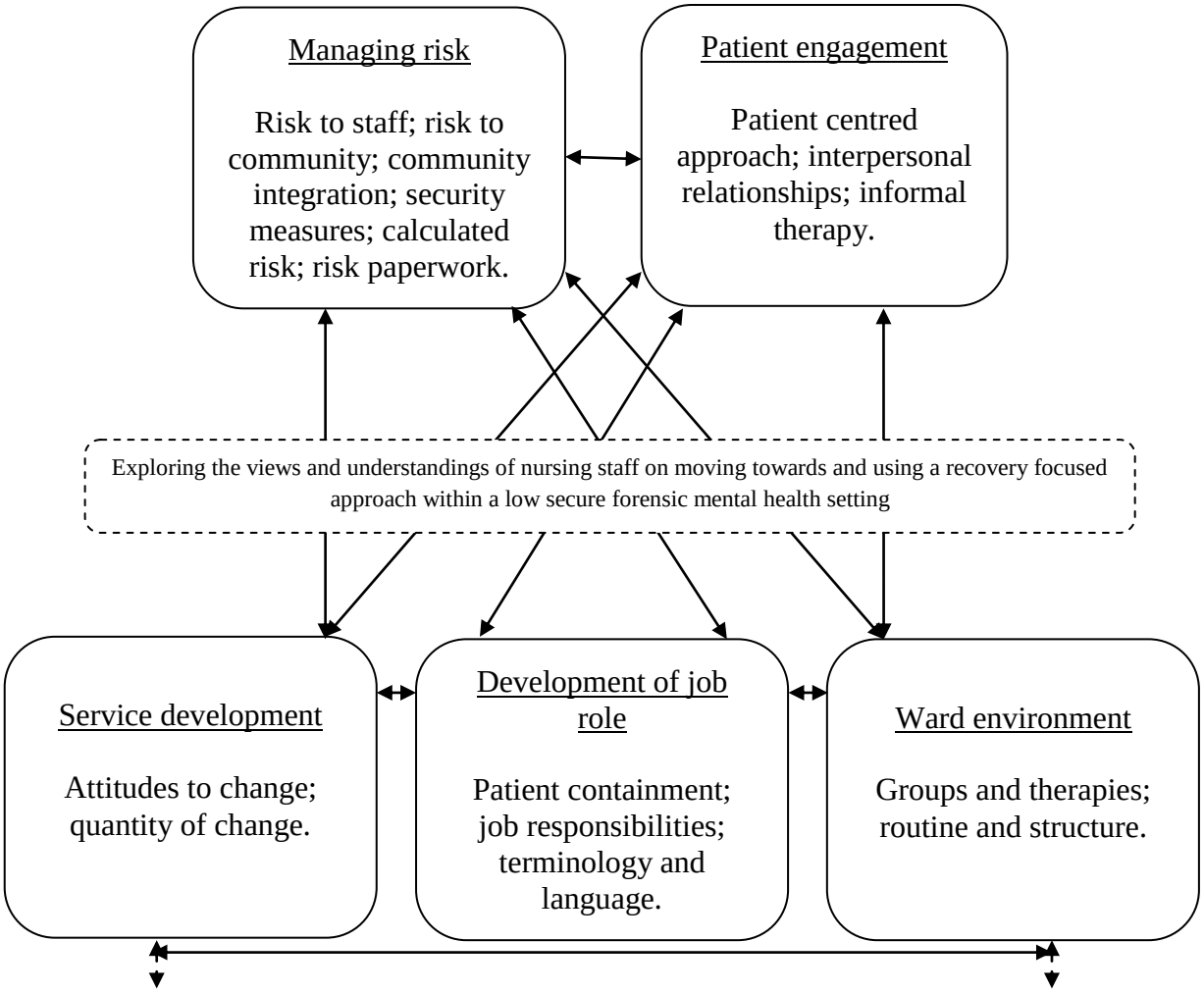

Figure 3.1 – main themes resulting from Framework Analysis of interviews with nursing staff

Ward environment

The first theme concerned the ward environment. Positive attitudes were observed when nursing staff discussed the two sub-topics domains of groups and therapies, and routine and structure.

Groups and therapies

All nursing staff reported that the implementation of the recovery focused approach had brought about positive changes in regards to additional therapies for the patients, specifically input from psychology and occupational therapy. Moreover, they reflected on the positive impact of more multidisciplinary working between professionals within the service.

> *All different members of the MDT are more involved down here... you did have psychology, but then it was very sparse...whereas here they're at the forefront of everything, so that's definitely a big difference, and the OT involvement as well.* (P6)

> *Having OT and psychology on site is a big help in making staff see it all as a positive step forward you know? These things just weren't around before; other disciplines sort of seemed non-existent back then. It's definitely a positive thing in my books.* (P8)

Moreover, nursing staff expressed their awareness of the benefits of additional groups and activities, and demonstrated an understanding of the direct link between these positive changes and the approach.

The 'road to recovery' group, it's good. Umm we focus on recovery, staying well and getting the patients back into the community. Umm it uses some CBT concepts and it helps a lot to build rapport with the patients too. (P1)

Here there loads and loads of different groups...there's definitely a lot more support for the patients I'd say and a lot more activities to keep them occupied. (P4)

Nursing staff reflected on the patient centred nature of the activities, with patients now having the opportunity to select activities of personal preference to themselves and their own recovery needs. Nursing staff perceived this aspect to be a positive change in promoting independence and decision-making skill in patients.

You've got different things going on every morning, afternoon and night, which they don't all participate in right enough, but at least they've got the option. They are asked what they want to do with their time now. They are now involved in their own decisions and treatment. (P8)

Routine and structure

Six nursing staff discussed how the addition of therapies and activities on the ward had given days more of a structure and routine, and had reduced time spent ruminating about their current difficulties and provided positive distractions from psychotic symptoms.

Now you've got groups like art, music, gardening, breakfast club, walking groups and so on you know. It's great for the guys as they now have a structure to their days; less time to sit and think about their lack of freedom. (P7)

More routine, they're less bored I think....less time to sit and do nothing, distracting them from their voices in their heads. (P11)

More specifically, a number of nursing staff reflected on the long term patient benefits of having a structured daily routine on the wards.

They've now have a structure and routine which they can abide by, that's a good thing for their recovery when they're back in the community. It's a good thing to instil early on I think. (P8)

Service development

The second theme concerned service developments within the forensic mental health service. Interview contents fell into two subtheme domains of attitudes to change and quantity of change.

Attitudes to change

It was apparent that the transition period of change had been challenging and had triggered adjustment difficulties and resentment amongst staff. Nursing staff reflected that the

service had not experienced significant changes before; hence changes in location, management and practice were overwhelming to many staff.

> *Nobody liked the changes; some people left and others, I mean well there was a lot of resentment and fighting against the change, but that was just because they'd done it a certain way for 100 years so why change it.* (P4)

> *There's a lot of staff in here who have been doing the job for quite a number of years and they were set in their ways, so it was more, them trying to adapt to change, which some people have found hard, it's natural I think, everyone likes their comfort zones and then to be taken out of that is going to be problematic.* (P6)

> *Like with any change you just grin and bear it I think, aye. I'm not saying recovery isn't good, I just think it's more the way it's been handled here could have been better you know. No one likes change anyway do they?* (P9)

In regards to the changes, staff reported feelings of low ward morale and motivation.

> *I'd say that the staff, the ward staff, the mood is pretty low at the moment.* (P5)

> *They haven't got the same volition, motivation; they just do what they have to do.* (P9)

Many nursing staff did conclude that regardless of their own personal difficulties adjusting to the transitions, they viewed these changes as advantageous for their patients.

Even though it's been ups and downs, and challenging for us staff, for the patients it's all been good, like I said, they have a voice now, patient centred and all that. (P8)

Better for the patients but harder for us (laugh). (P11)

Quantity of change

Nursing staff articulated feeling overwhelmed by the quantity of changes they have encountered within their work environment within a short period of time.

At the end of the day there will always be changes, but quite slight and slow, but it's been a big turnaround, it's been a massive transformation for staff and patients, so it does naturally take a little bit of time to adjust. (P6)

In isolation, any of those changes would be fine, but all together I guess it's just been more of a hassle to get your head round and that, does that make sense? It's all positive, all the changes and that, it's just all come at once so it is harder to grasp and get your head round. (P8)

Moreover, nursing staff expressed their dissatisfaction at the high level of staff turnover, with many commenting that new staff had recovery knowledge, however lacked the experience of working within a secure facility. Some staff reflected that the period of transition was made more challenging as they not only had to adapt to a new approach to patient care, but also had to educate new staff in the procedural security of the ward.

It's totally agreeable that we need new staff with new ideas, but not everybody at the one time, not flooded by people who are still learning. We need people who know what they are doing in forensic situations, a 50/50 mix not a whole shift of new people who are still learning from you, it puts you under pressure. (P2)

Moreover, one member of staff referred specifically to the example of new members of nursing staff responding to an assault, describing the high level of staff turnover having a negative impact on rapport, support and trust between staff members.

I suppose I just made the assumption that they're gonna come to my aid here, but they didn't because they were new and they froze. They didn't feel confident in the environment... So I do think it does take a wee while to build up trust, and staff turnover has been so high in here. (P7)

Development of job role

Nursing staff frequently discussed issues regarding the development of the forensic mental health nursing role, with topics discussed in the context of patient containment, job responsibilities and terminology and language.

Patient containment

Nine nursing staff described a positive transition away from a traditional containment and observational nursing role to that of a recovery approach to patient care.

I still have lots of memories of the old kinda 'turn key' way of working in the old place; it was more focus on containment and control. (P2)

Mostly I'd say my role, it was just observation and containment, aye that's what it was basically. (P5)

Nursing staff demonstrated awareness of the transition away from institutionalised care being one of importance in terms of instilling patient hope and a patient centred approach.

It's not just about containment and control, there's someone behind the walls, its giving the patients hope and focus. (P2)

Moreover, some nursing staff referred specifically to the approach significantly reducing time spent in hospital, thus reducing institutionalisation and segregation from the community.

It's all recovery focused now, keep them here for as little time as possible instead of years and years; it's a good thing! (P11)

Job responsibilities

Nursing staff described their job roles as changing, reporting a more diverse and demanding role involving escorting patients to local amenities, and facilitating ward activities.

Sometimes I think a lot of the staff feel like the jack of all trades. (P6)

We used to just contain the patients whereas here, it's 'all singing all dancing'. (P9)

Some nursing staff specifically commented on their unhappiness and frustration on their perceptions that their job no longer corresponded to their nursing qualification.

We have to do a lot more escorted visit to the shops, which I sometimes question, is that our job? Sometimes I think it's a waste of our nursing skills. (P8)

Terminology and language

A third of nursing staff reflected that they did not perceive nursing practices and procedures to have changed, stating that language and terminology utilised to describe recovery were the only aspects of ward life to have altered.

It wasn't addressed as recovery, it was all about 'when you get discharged, when you get moved', that was what the patient wanted to know and the language they understood. (P3)

When I think of your recovery, I just think we use different words, that's all. In all honesty, I think when you look at 'recovery' now, we looked at 'progress'...same thing! We would have looked at 'problem and need' rather than saying recovery. (P10)

Managing risk

Throughout the analysis, themes were identified that made reference to the management of risk. The index categories that best described the management of risk included risk to staff; community integration; risk to the community; security measures; calculated risk, and risk paperwork.

Risk to staff

Four members of the nursing staff reflected on service changes altering their perceptions regarding their own safety when on the ward.

> *Sometimes it's more focused on patient-centred instead of our safety, so our safety can be put at risk...our safety is compromised you know...I mean I do sometimes come away from situations and think 'aye that could have been messy' you know?* (P1)

> *We're doing more with the patients, one on one and in groups and that. I think it's purely down to luck that there haven't been all that many incidents, as it really could kick off at any time here. With the patients getting more freedom and choice, which is the recovery approach in a nut shell, I think it does increase safety risks to staff aye.* (P2)

Community integration

The low secure forensic mental health ward relocated from a rural setting to an urban, community-based location. It was apparent that overall views of this relocation were positive, having a positive impact on patient recovery and reintegration back into the community, compared to the previous rural location that was described as detached and isolated.

> *Here's just more integrated and community based instead of having the secure location away from people and from life.* (P5)

> *They've that wee bit more independence, plus its getting them back into normality and away from institutional isolation if that makes sense aye.* (P11)

> *Coming down here was great for them (patients); because they've got all the facilities out there in the community for them do you know what I mean? You can take them down the shops, take them into Morrison's, they can go to the library...whereas in the old place there was nothing!* (P4)

Risk to the community

Regardless of the positive aspects of the relocation of the ward, nursing staff acknowledged the potential elevated risks of this to the community.

Patients, they stagnated for a long long time, care was asylum based, then all of a sudden they've knocked them all down, and now they all live out in the community, do you think that's safe? (P9)

More risk for the community what with us being based so central, but the community don't know that as they don't really know of this unit; surely that's a risk in its self? (P8)

Some nursing staff, however, described patients being more restricted within the new community-based location, due to perceived high levels of imminent risk to vulnerable members of the community.

To go get a coffee or something they have to go off site to do that, down to like the supermarket or something like that, and assessments have to be done and sometimes stop that happening...ironically, they're probably more restricted now than they were before. (P3)

Security measures

Participants described the modernisation of the new purpose built forensic mental health facility having resulted in higher security measures within the ward.

We've got swipes and magnets and keys, so there's a lot more security, you know we've got the secure glass as well...everything is locked away as well, they have to ask for everything and anything. (P9)

Calculated risk

Six participants mentioned the new process of calculating patient risk in association with the recovery approach. It was apparent that in the old facility, level of risk was managed through the avoidance of difficult situations and the reduction and prohibition of opportunities. Nursing staff reflected on this service transformation as being challenging, but, overall, a positive change.

> *In the old place I want to say that it was more like 'ooh don't take that risk', avoid all risk, keep them locked up, and lock the doors. It's definitely not like that now... it's now about positive risk taking and calculated risk, and how we manage the risk.* (P4)

> *It's all recovery focused now, calculated risk taking, so folk can go out to the shops and that, but instead of saying 'no way, you can't go out', now it's like 'yes you can but only if x y z are ok first'.* (P11)

Risk paperwork

Participants expressed their frustration and displeasure at the volume of paperwork, having to document every aspect of the ward environment and having to evidence every aspect of recovery in line with recovery legislations, including the Care Programmes Approach (Rethink Mental Illness, 2013) and Memorandum of Procedures on Restricted Patient (Scottish Government, 2010).

I feel that there is a lot of the paperwork, I mean everything is about risk assessments. We're risk assessing all the time and rightly so, but I feel like we're spending more time doing risk assessments and documenting everything, evidencing everything to cover managements' backs. (P3)

Moreover participants reflected on their dissatisfaction with increasing paperwork having a negative impact on patient contact time. They reflected that this was a negative aspect of the recovery focused approach, with patient interaction reduced due to increasing paperwork.

There's that much paperwork now, and you're constantly filling in forms, so we don't spend as much time actually sitting and socialising with the patients. I'd say that was a negative actually. (P4)

I do think there's an awful lot of paperwork now, all being risk focused. I mean, there are some shifts you do get where you're bogged down with paper work and you think, 'how am I supposed to write a report cos I've never seen a patient today.' (P7)

Patient engagement

The fifth and final theme is related to the importance of patient engagement, with this being described in terms of the subtheme domains of: adopting a patient centred approach; interpersonal relationships between staff and patients, and the value of informal therapy.

Patient centred approach

Ten nursing staff discussed the positive nature of the patient centred approach to care, with patients now having greater opportunity to be involved in their care; thus having greater control over their own lives, care and recovery.

> *Back in the old ward, nurses had to escort patients to court, which wasn't very nice as it was a public court so everyone could see what was going on. Whereas now they (Mental Health Tribunals) are on site, so they're more discrete, they maintain patient dignity and are more patient focused.* (P3)

> *They own a voice now; I think that's more of a thing now. They're more valued, can say what they're looking for, it's not just, well this is what's going to happen, and just like it or lump it kind of thing. They're now involved in their own care and recovery.* (P6)

Some nursing staff reflected on adopting a strengths-based approach to patient care, describing positive changes in both staff and patient levels of optimism and positive thinking.

> *I do think it's better; it's better for the patients to be more involved and I supposed to pick up on more of their strengths rather than always kinda focusing on the negative symptoms.* (P7)

> *I think it's good, more person centred and all that. The patients get more say in what they do and don't do, and what they want when they get out of here and that. It's all*

very positive now; strengths focused; what they can do rather than what they can't do. (P11)

Nursing staff also discussed positive changes in regards to the individualised nature of patient care, specifically referring to care plans now being tailored to patients' individual needs and goals, rather than underpinning generic diagnoses and symptoms.

They're not so generic, the care plans. They don't tend to focus as much on maybe, 'oh here's what a care plan for a person with schizophrenia looks like', it's more kinda 'here's the symptoms that this individual person has with schizophrenia'. (P7)

Each care plan is now tailored to their own need and their own risks and their diagnosis, aye very much a person centred approach now. (P11)

Interpersonal relationships

Six nursing staff disclosed that they perceived the approach to have had a negative effect on their interpersonal relationships with patients. For reasons, including increased work load; paperwork; facilitating groups, and escorting patients to the shops, nursing staff expressed their disappointment at having reduced time to interact socially with the patients.

We don't spend as much time actually sitting and socialising with the patients. I'd say that was a negative actually...in regards to the interpersonal relationship to the patient, it's not as good here, definitely not as good here. (P4)

I think this recovery stuff does change your relationship with the guys, I mean it's obvious really, you're spending less time with them chatting and asking questions informally you know, so naturally a therapeutic relationship is going to change. (P6)

Sitting and just chatting to patients, it helps normal socialising skills and relationships with staff as well you know. Whereas we don't get that same relationship down here I don't think. (P7)

Informal therapy

Nursing staff expressed their concerns regarding the negative impact that reduced patient contact time had on gaining information from their patients, regarding their mental and physical health and well-being. They articulated that due to more consuming ward demands, informal contact time and thus informal therapy has diminished. It would appear that nursing staff feel that this is a disadvantage, as this is an aspect of nursing practice that both they and the patients value.

Back in the old place, I used to quite often go in and sit at night, and bring a pack of cards and before you knew it you'd found all sorts of things about that person...almost like unofficial therapy. You found out an awful lot about their views, their personality, why they were being so suspicious or paranoid. (P3)

That's a sort of therapy in itself aye, speaking to people informally and that, that's not there anymore I don't think which is a shame; shame for us and the patients I think. (P7)

Nursing staff commented on the physical environment, specifically the small day rooms as being a barrier to patient interaction and informal therapy.

> *When the patients are in there at night, you cannot get a seat in that day room, and then it's as though you're kinda spying on them cos you've got to stand at the door which isn't right cos you wanna be able to go in and sit among them.* (P7)

> *The old day rooms gave way to more interactions between the staff and the patients...whereas, here there isn't any room in the day rooms, there's hardly anywhere for a member of staff to go and join patients.* (P10)

Nursing staff described their experiences of informal contact with the patients as having a significant effect on detecting early warning signs of deterioration and relapse. It was apparent that this aspect of their nursing practice was viewed as important yet perceived as devalued following changes.

> *You could see the warning signs before they got too ill, we knew because we knew them so well. You could say "oh he's no right. I can't put my finger on it, but he's no right", so you could intervene quicker.* (P4)

> *It was like informal therapy which I think is important because that's when we saw the changes in patients, and we could pick up anything like that (click fingers) off them, how they were behaving, how they were...because they would maybe forget you were there.* (P10)

Discussion

Overall findings from this study indicated that interviewed staff supported the organisational and programmatic changes within the low secure forensic mental health service towards a recovery focused approach. Ten out of eleven participants were in favour of the approach, describing a belief in the value of recovery principles, and positive experiences implementing and utilising the approach within their practice. Framework Analysis identified five themes which related to: ward environment; service development; development of job role; managing risk, and patient engagement. There were some similarities with previous research with regards to more multidisciplinary involvement (Gudjonsson et al., 2010); adopting a patient centred approach to care (Cleary et al., 2013); increasing staff recovery knowledge (Gale & Marchall-Lucette, 2012; McLoughlin & Fitzpatrick, 2008), and changing staff recovery attitudes (Warner, 2010) and motivation (Hurley & McKay, 2009; Piat et al., 2010). However, unlike previous research, findings from this study indicated that regardless of positive attitudes and experiences utilising recovery principles, all staff commented on constraints of the approach, which acted as a barrier when implementing changes.

Within the present study, nursing staff reflected that, regardless of their own personal difficulties adjusting to the transitions, overall benefits were evident within the service. Gudjonsson et al. (2010) demonstrated similar findings, with the approach having a positive impact on staff and patients. However, unlike Gudjonsson et al. (2010), data from this study described an initial level of staff resistance to change, but that over time, staff described a process of engagement with, and acceptance of, the changes. This would appear to be a novel finding within this field of research, and highlights the fact that attitudes and experiences may need time to change. Gudjonsson et al.'s (2010) study found evidence that staff viewed the

involvement of the wider multidisciplinary team as beneficial. These findings are congruent with those of the present study, and offer support to the finding that the multidisciplinary style of working on the ward was a positive aspect to arise from programmatic changes. Nursing staff within this study reflected on the direct link between this change and the recovery approach, and the positive impact this change had on them, the patients and their relationships.

The subthemes of adopting a patient centred approach and a movement away from patient containment and control were described by staff as being positive. Staff discussed observing first-hand the positive impact of a more patient centred service, reflecting positive effects on their employment experiences, interpersonal relationships with patients and on the patients' rate of recovery. These results are similar to those of Cleary et al. (2013), who found that mental health nurses reflected on individualised person-centred care as a positive recovery focused change. Of interest, within the present study, a third of nursing staff felt that a patient centred approach had always been a key aspect of mental health nursing practice both before and after changes were implemented. Hurley and McKay (2009), in their research with occupational therapists, also indicated that they perceived the impact of the approach as minimal, stating that their practice was already patient centred prior to change. However, participants in the current study felt that adopting a strengths-based approach was a new and positive change to arise. This finding is important as it identifies information regarding aspects of the approach that staff value and perceive to have facilitated and benefited their roles, relationships and practice.

Perceptions of patient empowerment were demonstrated in the current study and evidenced in the subtheme of 'groups and therapies'. Participants reflected on the patient

centred nature of the ward groups and therapies, discussing how patients had the opportunity to select activities of personal preference to themselves and their own recovery needs. Warner (2010) also found evidence to suggest that empowerment was an important facilitating component of recovery for both staff and patients. In the current study nursing staff perceived the aspects of empowerment and the patient centred nature of the approach to be important positive changes in promoting independence and decision-making skills in patients. Nursing staff appeared to support and value these aspects, reporting them having a positive impact on themselves too.

Overall, staff supported the organisational and programmatic changes, however many staff reported constraints and barriers to change, which included having to occupy a more diverse and demanding role. It was apparent that they were ambivalent about these changes in terms of their job responsibilities and practice, with some nursing staff reporting feelings of low ward morale, motivation and disempowerment following the large number of changes that had occurred within a short time frame. This is concerning, as Moos and Schaefer (1987) have argued that staff morale is of fundamental importance when striving towards a recovery climate. Previous research by Rossberg and Friis (2004) described staff satisfaction being of increasing importance when implementing the recovery approach, having a direct impact on therapeutic social climate, with negative staff attitudes and low motivation perceived as barriers to recovery. Thus, the current study suggests the importance of future research to further investigate the impact that low staff confidence, mood and motivation has on experiences of implementing and accepting service changes. It has been noted in other related research that low staff motivation is associated with changing job responsibilities and role, and may be implicated in future staff sickness (Chang, Hancock, Johnson, Daly, & Jackson, 2005) and high staff turnover (Edwards & Burnard, 2002).

In the interviews all respondents discussed their perceptions of what both promoted and impeded the implementation of the approach. Nursing staff identified factors that impeded the approach which included the challenges of how the changes impacted on the management of risk to staff and the community, which was associated with an increase in risk paperwork and the reduced amount of time available for informal contact and the maintenance of interpersonal relationships between staff and patients. This is of interest as the role of nursing staff within forensic settings has traditionally had the management of risk as central to their role. What was different about the new approach was that risk management and its associated risk paperwork, while in line with new government policies (NHS, 2012), was felt by nursing staff to actually reduce informal contact and impeded patient engagement. Paradoxically, this aspect of implementing the new approach in relationship to management of risk resulted in a negative impact on its central therapeutic goal. This finding is important as it highlights issues regarding current ward processes, which appear to hinder the ability of staff to fully accept and adopt the approach. Changes within the forensic service, brought with it more paperwork, and took staff away from elements of their work that they valued and found rewarding, primarily being that of patient contact time. It is of interest that staff described the changes as more rewarding if constraints, such as paperwork were reduced to make time available to focus on elements of their work they perceived to be more important. It would appear that organisational and programmatic changes had changed elements of practice that staff valued, with this impacting negatively on them and their relationships with patients. Gilburt, Rose and Slade (2008) have also highlighted the importance of the therapeutic relationship in providing a safe and therapeutic milieu for the recovery of mental health patients. Hence, the benefits of patient engagement and informal contact, which were described within this study as being limited and de-valued, should not be overlooked, and merits consideration when scheduling the daily role and responsibilities of nursing staff.

Results from this study demonstrated the creation of a policy environment without sufficient consideration of the implications on staff and their relationships with patients. Thus, the balance between administrative and therapeutic work by nursing staff warrants further investigation, assessment and review by service management.

Strengths and limitations of the study

This study is one of the few to explore the views of forensic mental health nursing staff on moving towards and using a recovery focused approach within a low secure forensic mental health service. Qualitative methodology was selected as the research method within this study, in an attempt to address some of the gaps in the forensic mental health research field, through the exploration of complexities surrounding nursing staff members' subjective knowledge and perceptions, thus facilitating an in-depth understanding of their experiences. Findings from this study provide new information regarding factors that staff perceived to promote and impede recovery oriented changes. Nursing staff were recruited from across the whole of the mental health nursing staff population employed within the forensic service. Therefore, this study sample is likely to go some way in representing the wider population of mental health nurses employed within low secure inpatient forensic mental health services.

There are a number of methodological limitations of this study; therefore the results should be interpreted with caution. Firstly, the sample size was small and self-selected (given that participants volunteered to be interviewed), hence reducing the ability to generalise the results to the wider mental health nursing population. There was, however, a marked consistency in the narratives provided by the participants, suggesting a level of homogeneity. Secondly, the facility had gone through a number of changes over a short period of time,

hence this may be a confounding variable. For example, the increase in paperwork may not necessarily be directly and solely attributed to the recovery approach, but also other variables such as NHS policies and national guidelines, including the Care Programmes Approach (Rethink Mental Illness, 2013) and Memorandum of Procedure on Restricted Patients (Scottish Government, 2010). Control for such confounding variables is thus recommended for future research.

Thirdly, Framework Analysis is a qualitative technique that is open to researcher bias when identifying emergent themes (Howell, 1992). In an attempt to minimise researcher bias, the researcher was reflective and remained close to the original data, avoiding abstract interpretations. A high inter-rater reliability was evident between the primary and secondary raters, with all discrepancies reviewed and discussed. With both researchers coming from a psychology background, it is possible that this had some influence on the data and emergent themes. However, in using a structured framework approach which fosters transparency, it is felt that any bias would have been minimised (Ritchie & Lewis, 2003; Smith & Firth, 2011).

Finally, the quality of the narrative data was reliant upon the openness and motivation of nursing staff. On a number of occasions, the researcher perceived staff to be less forthcoming when describing their own perceptions of change, preferring to describe the workforce's views as a whole. Staff may have used the opportunity to portray themselves as supportive of management decisions, due to concerns that their contributions could be identified. Moreover, due to the relatively small subject pool, it is possible that other staff may have known who participated, thus interviews may be subject to social desirability effects which can reduce data validity, reliability and generalisability to the wider population of mental health nurses.

A number of strategies were implemented to overcome these barriers. Firstly, a participant information sheet (see Appendix H); consent form (see Appendix I), and explanation of confidentiality and right to withdraw were provided prior to interviews, in order to empower participants to feel in control within the study. Only one researcher conducted the interviews, in an attempt to strengthen the interviewer-interviewee relationship and to facilitate further honesty and openness (Seidman, 2012). Moreover the semi-structured nature of the interviews allowed participants to speak openly without constraints. Regardless of the strategies implemented to overcome such barriers, participant motivation and openness are still considered limitations; therefore the results should be interpreted with caution.

Future research

Further research could explore multiple perspectives on moving towards and using a recovery focused approach within a low secure mental health service which would include other professional groups employed within the service. Moreover, it would be of interest to conduct similar qualitative interviews with services users, to determine whether attitudes differ between professionals and service users (Rose, Thornicroft, & Slade, 2006). There may also be value in future research adopting a mixed-method analysis to data collection, thus strengthening data validity, reliability and generalisability. The physical environment of the forensic unit, specifically security measures and room size, emerged as having a negative impact on many of the participants interviewed. Thus the impact of the social and therapeutic atmosphere of the facility should be addressed within future research utilising existing measures, such as the Essen Climate Evaluation Schema (Schalast, Redies, Collins, Stacey, & Howells, 2008) and Ward Atmosphere Scale (Moos & Houts, 1968). This may further assist in the identification of specific factors that promote and impede the approach.

Implications for clinical practice

There is a need for the present study to be replicated on a larger scale, in the form of rolling out a pilot across similar forensic mental health services. This should include low, medium and high secure units, so results can be reflective of a broader forensic mental health nursing population. Within this study, management of risk was identified as a main theme. Thus, it is of interest to the principal researcher, to identify the effects of differing levels of service security and perceived patient risk on staff perceptions and experiences (Scottish Government, 2003). It would be important to ascertain if findings from this study are congruent across other forensic services, in order to evaluate if the recovery approach is an effective practice to patients, staff members and the overall organisation.

This study found new information regarding factors that promoted and impeded organisational and programmatic changes and the impact of these on staff experiences, which highlights some important implications in terms of service management policy and practice. This research has highlighted some of the difficulties and challenges associated with service changes and the move towards adopting a recovery approach. According to Uppal, Oades, Crowe and Deane (2008), in order to achieve the routine application of recovery principles in mental health services, training of practitioners is essential. Social Learning Theory (Bandura, 1994) and Social Constructivism (Vygotsky, 1978) are centred around learning that occurs within a social context (Rendell et al., 2011), with knowledge and understanding being acquired and sustained under the guidance of, or in collaboration with others (Vygotsky, 1978). This study has identified whether staff perceptions are in keeping with the approach or not, with staff training recommended to further encourage and enhance recovery-oriented attitudes, skills and knowledge. In addition to recovery focused training, Clinical

Psychology Services could contribute to sustaining and prolonging recovery-oriented change by providing staff with confidential consultation and supervision. In support for practitioner reflection, adopting techniques of Positive Psychology (Seligman & Csikszenmihalyi, 2000), and other psychological processes such as Mentalization-Based Therapy (Fonagy & Bateman, 2008), Motivational Interviewing (Miller & Rollnick, 1991) and Compassion Focused Therapy (Gilbert, 2009), could further maintain self-efficacy and self-determination, whilst reducing economic costs of training.

Finally, this study has provided fundamental information regarding the approach and the impact of service changes on nursing staff, which helps service management understand how staff made sense of these changes and the impact on them, the patients and their relationships. Thus, these results need to be taken into consideration by service management when implementing organisational and programmatic changes in similar therapeutic environments. Maslow's Hierarchy of Needs theory (Maslow, 1954) assists service management in understanding an employee's motivation, management training needs, and personal development. It is the responsibility of service management to provide a workplace environment that is conducive to enabling employees to fulfil their personal and professional potential.

Conclusion

The results of this study provide insight into the views and experiences of nursing staff on moving towards and using a recovery focused approach within a low secure forensic mental health setting. These results are consistent with qualitative research from acute inpatient and community mental health services and with quantitative research within

forensic mental health research in recent years. However, results obtained provide new and important information regarding the perceived barriers and constraints to accepting and implementing recovery organisational and programmatic changes. Additional research is thus warranted to further investigate differences in attitude across all mental health professions and service users, moreover across similar forensic mental health services, to thus contribute to more efficient and effective patient care when implementing recovery principles within secure mental health settings.

References for Journal Article 2

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Appendices Contents

Appendix A – Clinical Psychology Review: Author Guidelines

CLINICAL PSYCHOLOGY REVIEW - AUTHOR INFORMATION PACK

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DESCRIPTION

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Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

Reviews on other topics, such as psychophysiology, learning therapy, experimental psychopathology, and social psychology often appear if they have a clear relationship to research or practice in **clinical psychology**. Integrative literature reviews and summary reports of innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies and theoretical treatises or clinical guides without an empirical base are not appropriate.

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2.Salyers et al (2007)	Not an intervention study with outcomes	PUBMED
3.Tsai and Salyers (2008)	Focus on therapeutic recovery environment	PUBMED
4. NHS (2010)	Review, not exploratory study paper	PUBMED
5.Pascaris et al (2008)	Critique of service – not impact of training programme	Web of Knowledge
6.Cleary et al (2013)	Not an intervention study with outcomes	Web of Knowledge
7.Shepherd et al (2008)	Review, not outcome exploratory study paper	Web of Knowledge
8.Marshall et al (2012)	Family carer population not mental health practitioners	PsycINFO
9.Uppal et al (2008)	Critique of training implementation– not impact of training on mental health practitioners	PsycINFO
10.Oades et al (2003)	Critique of training resources/delivery – not impact of training on mental health practitioner	PsycINFO
11.Oades et al (2005)	Patient population not mental health practitioners	MEDLINE
12.Slade et al (2009)	Critique of methodology – not impact of training on mental health practitioners	MEDLINE
13.Farkas et al (2005)	Critique of recovery training implementation – not impact of training on mental health practitioners	MEDLINE
14.Williams et al (2012)	Systematic review of recovery orientation measures	MEDLINE
15.Halpern et al (2009)	Patient population not mental health practitioners	MEDLINE
16.Storey et al (2008)	Critique of service – not impact of training programme	MEDLINE
17.Deane et al (2013)	Organisational service impact of training not mental health practitioners	Science Direct
18.Sun et al (2013)	Focus on working alliance	Science Direct
19.Roberts et al (2011)	Critique of recovery training implementation – not impact of training on mental health practitioners	Science Direct
20.Piat et al (2010)	Review, not outcome exploratory study paper	Science Direct
21.Priest et al (2011)	Focus on working alliance	Science Direct
22.Ramon (2011)	Review, not outcome exploratory study paper	Science Direct

Appendix C – Qualitative study quality assessment checklist

Checklist items are worded so that 1 of 5 responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
–	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
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Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

1. Theoretical approach		
1.1 Was a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	++ + – NR NA	Comments:
1.2 Was there a clear statement of the aims of the research? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	++ + – NR NA	Comments:
2. Study design		
2.1 Was the research design appropriate to address the aims of the research? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	++ + – NR NA	Comments:
3. Data collection		
3.1 How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	++ + - NR NA	Comments:
4. Trustworthiness		
4.1 Was the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	++ + - NR NA	Comments:
4.2 Was the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances	++ + – NR NA	Comments:

• Was context bias considered		
4.3 Were the methods reliable? For example: • Was data collected by more than 1 method? • Do the methods investigate what they claim to?	++ + - NR NA	Comments:
5. Analysis		
5.1 Was the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	++ + - NR NA	Comments:
5.2 Was the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	++ + - NR NA	Comments:
5.3 Was the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	++ + - NR NA	Comments:
5.4 Was there a clear statement of findings? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	++ + - NR NA	Comments:
5.5 Are the findings generalisable to the source population (i.e. externally valid)? Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	++ + - NR NA	
5.6 Do the results of this study fit with other available evidence?	++ + - NR NA	
5.7 What are the implications of this study for practice?	++ + - NR NA	
1.8 Conclusions **Was there adequate discussion of any limitations encountered?** For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic?	++ + - NR NA	Comments:

• Are the implications of the research clearly defined?		
6. Ethics		
6.1 How clear and coherent were the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	++ + - NR NA	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted?	++ + –	Comments:

Appendix D - Mixed-methods study quality assessment checklist

Checklist items are worded so that 1 of 5 responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
–	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
Not reported (NR)	Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered.
Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

1. Screening Questions		
1.1 Was a mixed-method approach appropriate? For example: • Could just a qualitative or quantitative approach better have addressed the research question?	++ + - NR NA	Comments:
1.2 Was there a clear statement of the aims of the research? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? Are underpinning values/assumptions/theory discussed?	++ + - NR NA	Comments:
1.3 Was the research design appropriate to address the aims of the research? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? Is the selection of cases/sampling strategy theoretically justified	++ + – NR NA	Comments:
2. Population		
2.1 Was the source population or source area well described? Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?	++ + – NR NA	Comments:
2.2 Was the eligible population or area representative of the source population or area? Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups under-represented?	++ + – NR NA	Comments:
Section 3: Trustworthiness		
3.1 Was the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? Does the paper describe how the research was explained and presented to the participants?	++ + – NR NA	
3.2 Was the context clearly described? For example:	++ +	

• Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances Was context bias considered	- NR NA	
3.3 Were the methods reliable? For example: • Was data collected by more than 1 method? Do the methods investigate what they claim to?	++ + –	
Section 4: Outcomes		
4.1 Were outcome measures reliable? Were outcome measures subjective or objective? How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + – NR NA	Comments:
4.2 Were all outcome measurements complete? Were all or most study participants who met the defined study outcome definitions likely to have been identified?	++ + – NR NA	Comments:
4.3 Were all important outcomes assessed? Were all important benefits and harms assessed? Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
4.4 Were outcomes relevant and reliable? Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership – a potentially objective outcome measure – but is it a reliable predictor of physical activity?)	++ + - NR NA	Comments:
4.5 Was the follow up of subjects complete enough? If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + - NR NA	Comments:
4.6 Was follow-up time of subjects meaningful? Was follow-up long enough to assess long-term benefits or harms? Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 5: Analyses		
5.1 Was there a clear statement of findings? What are the bottom line results? Have they reported the rate or the proportion between the exposed/unexposed, the ratio/the rate of difference**?**	++ + – NR NA	Comments:
5.2 Was the study sufficiently powered to detect an intervention effect (if one exists)? A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	++ + – NR NA	Comments:
5.3 Were the analytical methods appropriate? Were important differences in follow-up time and likely confounders adjusted for? If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)? Were subgroup analyses pre-specified?	++ + – NR NA	Comments:

5.4 Was the precision of intervention effects given or calculable? Were they meaningful? Were confidence intervals or p values for effect estimates given or possible to calculate? Were CI's wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:
Section 6: Summary		
6.1 Are the study results internally valid (i.e. unbiased)? How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design?	++ + –	Comments:
6.2 Are the findings generalisable to the source population (i.e. externally valid)? Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	++ + –	Comments
6.3 Do the results of this study fit with other available evidence?	++ + -	
6.4 What are the implications of this study for practice?	++ + -	
6.5 Was there adequate discussion of any limitations encountered? For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? Are the implications of the research clearly defined?	++ + - NR NA	
6.6 How clear and coherent were the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? Was the study approved by an ethics committee?	++ + – NR NA	
Overall Assessment **As far as can be ascertained from the paper, how well was the study conducted?**	++ + -	

Appendix E - Quantitative study quality assessment checklist

Checklist items are worded so that 1 of 5 responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed or conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
–	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
Not reported (NR)	Should be reserved for those aspects in which the study under review fails to report how they have (or might have) been considered.
Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

2. Screening Questions		
1.1 Was a quantitative approach appropriate? For example: • Could a qualitative approach better have addressed the research question?	++ + - NR NA	Comments:
1.2 Was there a clear statement of the aims of the research? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? Are underpinning values/assumptions/theory discussed?	++ + - NR NA	Comments:
1.3 Was the research design appropriate to address the aims of the research? For example: • Is the design appropriate to the research question? • Is a rationale given for using a quantitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? Is the selection of cases/sampling strategy theoretically justified	++ + - NR NA	Comments:
2. Population		
2.1 Was the source population or source area well described? Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?	++ + – NR NA	Comments:
2.2 Was the eligible population or area representative of the source population or area? Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups under-represented?	++ + – NR NA	Comments:
Section 3: Outcomes		
3.1 Were outcome measures reliable? Were outcome measures subjective or objective? How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	++ + – NR NA	Comments:
3.2 Were all outcome measurements complete? Were all or most study participants who met the defined study outcome definitions likely to	++ +	Comments:

have been identified?	– NR NA	
3.3 Were all important outcomes assessed? Were all important benefits and harms assessed? Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
3.4 Were outcomes relevant? Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership – a potentially objective outcome measure – but is it a reliable predictor of physical activity?)	++ + - NR NA	Comments:
3.5 Was the follow up of subjects complete enough? If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + - NR NA	Comments:
3.6 Was follow-up time of subjects meaningful? Was follow-up long enough to assess long-term benefits or harms? Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 What are the results of this study? What are the bottom line results? Have they reported the rate or the proportion between the exposed/unexposed, the ratio/the rate of difference**?**	++ + – NR NA	Comments:
4.2 Was the study sufficiently powered to detect an intervention effect (if one exists)? A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	++ + – NR NA	Comments:
4.3 Were the analytical methods appropriate? Were important differences in follow-up time and likely confounders adjusted for? If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)? Were subgroup analyses pre-specified?	++ + – NR NA	Comments:
4.4 Was the precision of intervention effects given or calculable? Were they meaningful? Were confidence intervals or p values for effect estimates given or possible to calculate? Were CI's wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design?	++ + –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	++ + –	Comments
5.3 Do the results of this study fit with other available evidence?	++ + -	

5.4 What are the implications of this study for practice?	++ + -	
5.5 Was there adequate discussion of any limitations encountered? For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? Are the implications of the research clearly defined?	++ + - NR NA	
5.6 How clear and coherent were the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? Was the study approved by an ethics committee?	++ + - NR NA	
Overall Assessment **As far as can be ascertained from the paper, how well was the study conducted?**	++ + -	

Appendix F – International Journal of Forensic Mental Health: Authors Guidelines

International Journal of Forensic Mental Health – Author Guidelines

Aims & scope

The International Journal of Forensic Mental Health provides an international forum for disseminating research and practical developments to forensic mental health professionals. Forensic populations include both adults and youth involved in the criminal justice system, particularly mentally disordered offenders and sex offenders. The focus is on forensic issues such as criminal responsibility, competency or fitness to stand trial, risk assessment, family violence, and treatment of forensic clients. The journal reflects the international audience represented by the International Association of Forensic Mental Health Services, and articles comparing the law and/or practice in different countries are encouraged. The journal is the official publication of the International Association of Forensic Mental Health Services, and the journal is a benefit of membership.

Instructions for authors

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Please note that the *International Journal of Forensic Mental Health* uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to the *International Journal of Forensic Mental Health* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes .

Manuscript. *International Journal of Forensic Mental Health* receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: http://mc.manuscriptcentral.com/UFMH . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as faciliating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via http://scholarone.com/services/support/ . If you have any other requests please contact the journal at rosenfeld@fordham.edu .

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permissions if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors

should also suppy a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Each author should be listed with his or her primary departmental affiliation and institution name, and city/state/country (where applicable).

References. References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. *Examples: Journal:* Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour* , 7(6), 417-427. doi: 10.1037/0096-3445.134.2.258
Book: Millman, M. (1980). *Such a pretty face.* New York: W.W. Norton.
Contribution to a Book: Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing jin the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color Illustrations. Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Color reprints can only be ordered if print reproduction costs are paid. Print Reproduction: $900 for the first page of color; $450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Proofs . Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt.

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Appendix G – Ethical Approval

NHS Lanarkshire

Miss Holly Newman
Trainee Clinical Psychologist
Beckford Lodge
Caird Street
Hamilton
ML3 0AL

R&D Department
Corporate Services Building
Monklands Hospital
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date 6th February 2013
Enquiries to Margaret Stewart
R&D Facilitator
Direct Line 01236 712445
Email margaret.stewart@lanarkshire.scot.nhs.uk

Dear Miss Newman

PROJECT TITLE: Moving towards a recovery focused approach in a low secure forensic mental health setting: Staff perceptions and understanding of the impact of service

R&D ID NUMBER: L12080

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire, Iona Ward, Beckford Lodge, Caird Street, Hamilton.

For the study to be carried out you are subject to the conditions outlined overleaf:

Cont/...

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and the Data Protection Act 1998.

- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website:

  http://www.show.scot.nhs.uk/cso/ or the Research & Development Intranet site: http://firstport/sites/randd/default.aspx.

- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.

- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.

- You must contact the R&D Department if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.

- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire.

- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.

- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.

- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

Raymond Hamill
Research & Development Manager

cc.

NAME	TITLE	CONTACT ADDRESS	ROLE
Miss Marianne Laird		The Queen's Medical Research Institute	Sponsor Contact

Appendix H – Participant Information Sheet

Moving Towards a Recovery Focused Approach in a Forensic Setting. Version 1. December 2012.

December 2012. Version 1.

Participant Information Sheet

Title: Moving towards a recovery focused approach in a low secure forensic mental health setting: Staff perceptions and understanding of the impact of service change.

My name is Holly Newman and I am a Trainee Clinical Psychologist in NHS Lanarkshire. I am required to undertake a thesis project as part of my Doctorate in Clinical Psychology at The University of Edinburgh and invite you to take part in the following study. However, before you decide to do so, I need to be sure that you understand firstly why I am doing it, and secondly what it would involve if you agreed. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you might have and, if you want, discuss it with others including your friends and family. I will do my best to explain the project to you and provide you with any further information you may ask for now or later.

What is the research about?

The present study aims to explore the views and understanding of nursing staff on moving towards and using a recovery focused approach within a low secure forensic mental health setting in NHS Lanarkshire. The impact and experiences of nursing staff from the recent changes on the Iona Ward are of interest to the researcher. Research will be conducted in Beckford Lodge in Hamilton. You will also be asked questions regarding which service changes have both facilitated and impeded the recovery focused approach.

Why have I been invited?

Nursing staff (over the age of 18 years old) employed by NHS Lanarkshire, who have been working on the Iona Ward (low secure mental health unit) and experienced the work environment before and after service changes were implemented, will be invited by the principal researcher, Holly Newman to take part in this study.

Do I have to take part?

Your participation within this study is entirely voluntary. It is up to you to decide to join the study or not. The principal researcher will describe the study and go through this information sheet. If once you have read and understood the Participant Information Sheet, and have agreed to take part in the study, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

After being given this participant information sheet, you will have 3 or 4 days to decide whether or not to participate within the study. If you agree to take part in the study, you will be asked to sign a consent form. The principal researcher, Holly Newman will take your consent to participant within the study. Those who wish to take part within the research study and who have completed the informed consent form will be contacted by the researcher to arrange a convenient date and time for an interview to take place.

You will be asked to take part in an interview carried out by the researcher, Holly Newman, within 2-3 weeks of agreeing to take part. The time and date of interview will be arranged to suit you and it will take place in Beckford Lodge in Hamilton. Interviews will be audio-recorded. The interviewer will ask you questions. This should take no more than 60 minutes.

What are the possible disadvantages and risks of taking part?

No adverse effects or pain will be experienced by participating in this study.

You may experience personal inconvenience and personal discomfort during the interview in discussing your experiences, but the chance of this is very small.

You have the right to withdraw from the study at any point as well as the right to not answer any questions you are not completely comfortable with. We will only use information collected with your full permission.

For your convenience, the interview will be held in your place of employment, with interview times made to fit around your availability. The study aims to reduce any intrusion or inconvenience you experience and to empower you to feel in control of your participation within the study. Expenses are not available for your participation in this study.

What are the possible benefits of taking part?

It cannot be promised that the study will help you but it is hoped that the information gathered from this study will help improve knowledge of the impact and experiences of staff regarding service changes in NHS forensic mental health facilities, to aid further improvements within the service. This could possibly have positive effects on the work environment for staff working in the low secure forensic mental health setting.

We will follow ethical and legal practice and all information about you will be handled in complete confidence.

Will all the data collected be confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves Beckford Lodge will have identifiable information removed so that you cannot be recognised. You have the right to check the accuracy of data held about you and correct any errors.

Collected data will be used as part of a Doctorate in Clinical Psychology from The University of Edinburgh, and will not be used in future studies. Data will be stored for a maximum of 22

months, within the secure confinements of Beckford Lodge, Hamilton. Normal high levels of security of medical documentation within a medical facility will be applied to the collected data. Only myself (Holly Newman, principal researcher) can access the data. Following this, data will be disposed of securely.

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason.

Will I find out the results of the study?

For those of you who are interested in the results obtained from the study, access to the results can be obtained from the principal researcher, Holly Newman. It is intended that the results obtained will be published as part of the Doctorate in Clinical Psychology thesis from The University of Edinburgh. You will not be identified in the report unless you have given your consent. This study is sponsored by The University of Edinburgh.

What are my rights?

If you believe that you have been harmed in any way by taking part in this study, you have the right to pursue a complaint and seek any resulting compensation through The University of Edinburgh who are acting as the thesis research sponsor. Details about this are available from the principal researcher.

You will be required to complete a consent form before participating in the study. You will be given a signed consent form to keep. Thank you for taking the time to read this Participant Information Sheet and for considering taking part in this thesis research study.

Contacts

If you have any further questions about the study please contact Holly Newman on: 07855152862 or email: h.e.newman@hotmail.co.uk, who will do her best to answer your questions.

If you wish to talk to someone who is not involved with the study or to make a complaint about the study please contact NHS Lanarkshire:

Raymond Hamill
Corporate Research & Development Manager
c/o Monklands Hospital
Monkscourt Avenue
Airdrie ML6 0JS
01236 712460

Thank you for taking the time to read this information sheet and for considering taking part in the research project.

Holly Newman
Trainee Clinical Psychologist

Appendix I – Consent Form

Moving Towards a Recovery Focused Approach in a Forensic Setting. Version 1. December 2012.

CONSENT FORM

Participant's Identification Number for this study: ☐

Title of Study: Moving towards a recovery focused approach in a low secure forensic mental health setting: Staff perceptions and understanding of the impact of service change.

Name of Researcher: Holly Newman, Trainee Clinical Psychologist.

	Please initial box
1. I confirm that I have read and understand the Participant Information Sheet dated December 2012 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that data collected during the study may be looked at by individuals from the University of Edinburgh or from NHS Lanarkshire where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I agree to the audio-recording of the interview.	☐
5. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 for participant, 1 for researcher site file.

Appendix J - Initial index framework of the themes and categories identified in three transcripts

THEMES	SUBTHEMES		PARTICIPANTS	
		PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3
managing risk	risk to self	line 59-64 & 69-71	line 86 & 203-205	X
	risk to community	X	line 22-28, 30-35, 173 & 199	line 132 & 143-144
	community integration	X	X	line 145-146
	security measures	X	line 71-74, 176-180	X
	calculated risk	line 91-93	line 58-61	X
	risk paperwork	line 29-33	X	line 150-164
patient engagement	patient centred approach	line 50	line 180-185	line 53, 119-121, 129-130
	interpersonal relationships	X	line 187	line 16, 19, 175, 176-185, 194-197
	informal therapy	X	X	line 184-186, 189-190
attitudes to the service	quantity of change	X	line 78	X
	attitudes to change	X	line 203	X
development of job role	patient containment	line 39	line 20-22, 67, 71 & 103	line 18
	job responsibilities	X	X	line 133-134, 150-151
	terminology & language	X	X	line 44-48
	staff turnover	line 43	line 80-89	X
structured environment	groups & therapies	line 47-49, 53-55 & 83-86	line 102, 111, 116-118, 126-135	line 101-108

Appendix K - Coding matrix from four transcripts

THEME	SUBTHEME			PARTICIPANTS	
		PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3	PARTICIPANT 4
managing risk	risk to self	line 59-64 & 69-71	line 86 & 203-205	X	X
	risk to community	X	line 22-28, 30-35, 173 & 199	line 132 & 143-144	line 90-92
	community integration	X	X	line 145-146	line 83-88
	security measures	X	line 71-74, 176-180	X	X
	calculated risk	line 91-93	line 58-61	X	line 92-96, 98-111, 161-165
	risk paperwork	line 29-33	X	line 150-164	line 134-136, 185-186, 196
patient engagement	patient centred approach	line 50	line 180-185	line 53, 119-121, 129-130	X
	interpersonal relationships	X	line 187	line 16, 19, 175, 176-185, 194-197	line 127, 129-133, 137-139, 141-143, 150, 183-185, 186-191
	engagement timing	X	line 152-156	X	line 22-29
	informal therapy	X	X	line 184-186, 189-190	line 192-195
service developments	quantity of change	X	line 78	X	line 52-61, 64-68
	attitudes to change	X	line 203	X	line 152-159, 179
development of job role	patient containment	line 39	line 20-22, 67, 71 & 103	line 18	line 90, 97
	job responsibilities	X	X	line 133-134, 150-151	line 22, 39-47, 197-198
	terminology & language	X	X	line 44-48	line 24
	staff turnover	line 43	line 80-89	X	line 59, 159
structured environment	groups & therapies	line 47-49, 53-55 & 83-86	line 102, 111, 116-118, 126-135	line 101-108	Line 22, 29-30, 118-125
	routine & structure	X	X	X	X

Appendix L - Coding matrix from seven transcripts

THEME	SUBTHEME	_	_	_	PARTICIPANTS
_	_	PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3	PARTICIPANT 4
managing risk	risk to staff	line 59-64 & 69-71	line 86 & 203-205	X	X
_	risk to community	X	line 22-28, 30-35, 173 & 199	line 132 & 143-144	line 90-92
_	community integration	X	X	line 145-146	line 83-88
_	security measures	X	line 71-74, 176-180	X	X
_	calculated risk	line 91-93	line 58-61	X	line 92-96, 98-111, 161-165
_	risk paperwork	line 29-33	X	line 150-164	line 134-136, 185-186, 196
patient engagement	patient centred approach	line 50	line 180-185	line 53, 119-121, 129-130	X
_	interpersonal relationships	X	line 187	line 16, 19, 175, 176-185, 194-197	line 127, 129-133, 137-139, 141-143, 150, 183-185, 186-191
_	engagement timing	X	line 152-156	X	line 22-29
_	informal therapy	X	X	line 184-186, 189-190	line 192-195
service developments	quantity of change	X	line 78	X	line 52-61, 64-68
_	attitudes to change	X	line 203	X	line 152-159, 179
development of job role	patient containment	line 39	line 20-22, 67, 71 & 103	line 18	line 90, 97
_	job responsibilities	X	X	line 133-134, 150-151	line 22, 39-47, 197-198
_	terminology & language	X	X	line 44-48	line 24
_	staff motivation				
_	staff turnover	line 43	line 80-89	X	line 59, 159
structured environment	groups & therapies	line 47-49, 53-55 & 83-86	line 102, 111, 116-118, 126-135	line 101-108	Line 22, 29-30, 118-125
_	routine & structure	X	X	X	X

PARTICIPANT 5	PARTICIPANT 6	PARTICIPANT 7
X	X	line 35-37, 40-47, 108-110, 124-125, 128-134
X	line 17-18	X
line 112	X	line 31-34
line 112	X	line 267
line 101-106	X	X
line 92-100	line 106-111	line 159-165, 206-207
line 30-32, 39-40, 86-87	line 35-39, 76-77, 87-90, 126	line 68-74, 76-78, 85-86, 152-156, 228-235
X	line 135-138	line 184-188, 207-209
X	line 113-116, 121, 124-125, 127, 129-135, 147-150	line 161, 168-170, 179-184, 188-194, 205, 218-220, 233-235
X	line 116-118, 138-143, 144-147	line 175
line 24/25	line 26-27, 135-138, 150-152	X
line 22, 51-52, 79-80, 88	line 52-58, 61-63, 92-98, 152-156	line 78-80, 88-91
line 91, 111	X	line 247-263m 267-269
line 50, 90-92,	line 99-106, 111-112, 152	line 145
X	X	line 61-62, 144-145,
line 78, 80	X	X
line 56-65	line 59-61	line 80-83, 100-110, 113-120, 126-128
line 34-38, 39/40, 46/47, 73-74	line 41-42, 78-82, 85-87	line 148-151, 158
line 66, 71-72, 83-84,	line 80-84	line 138-140, 147, 148-152, 158

Appendix M - Coding matrix from eleven transcripts

THEME	SUBTHEME			PARTICIPANTS	
		PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3	PARTICIPANT 4
managing risk	risk to staff	line 59-64 & 69-71	line 86 & 203-205	X	X
	risk to community	X	line 22-28, 30-35, 173 & 199	line 132 & 143-144	line 90-92
	community integration	X	X	line 145-146	line 83-88
	security measures	X	line 71-74, 176-180	X	X
	calculated risk	line 91-93	line 58-61	X	line 92-96, 98-111, 161-165
	risk paperwork	line 29-33	X	line 150-164	line 134-136, 185-186, 196
patient engagement	patient centred approach	line 50	line 180-185	line 53, 119-121, 129-130	X
	interpersonal relationships	X	line 112, 187	line 16, 19, 175, 176-185, 194-197	line 127, 129-133, 137-139, 141-143, 150, 183-185, 186-191
	engagement timing	X	line 152-156	X	line 22-29
	informal therapy	X	X	line 184-186, 189-190	line 192-195
service developments	quantity of change	X	line 78	X	line 52-61, 64-68
	attitudes to change	X	line 203	X	line 152-159, 179
development of job role	patient containment	line 39	line 20-22, 67, 71 & 103	line 18	line 90, 97
	job responsibilities	X	X	line 133-134, 150-151	line 22, 39-47, 197-198
	terminology & language	X	X	line 44-48	line 24
	staff motivation	X	line 99-101	X	line 155
	staff turnover	line 43	line 80-89	X	line 59, 159
ward environment	groups & therapies	line 47-49, 53-55 & 83-86	line 102, 111, 116-118, 126-135	line 101-108	Line 22, 29-30, 118-125
	routine & structure	X	X	X	X
	physical environment	X	X	line 127-129, 146-148, 176-180	line 76-78, 129-134

PARTICIPANT 5	PARTICIPANT 6	PARTICIPANT 7	PARTICIPANT 8
X	X	line 35-37, 40-47, 108-110, 124-125, 128-134	X
X	line 17-18	X	line 60, 62-65
line 112	X	line 31-34	X
line 112	X	line 267	X
line 101-106	X	X	X
line 92-100	line 106-111	line 159-165, 206-207	line 67-70
line 30-32, 39-40, 86-87	line 35-39, 76-77, 87-90, 126	line 68-74, 76-78, 85-86, 152-156, 228-235	line 19-20, 27-33, 46-48, 53-54, 87, 90-91
X	line 135-138	line 184-188, 207-209	X
X	line 113-116, 121, 124-125, 127, 129-135, 147-150	line 161, 168-170, 179-184, 188-194, 205, 218-220, 233-235	
X	line 116-118, 138-143, 144-147	line 175	line 70-74
line 24/25	line 26-27, 135-138, 150-152	X	line 79-85
line 22, 51-52, 79-80, 88	line 52-58, 61-63, 92-98, 152-156	line 78-80, 88-91	line 15, 85-86, 96-99
line 91, 111	X	line 247-263m 267-269	line 94-95
line 50, 90-92,	line 99-106, 111-112, 152	line 145	line 21-22, 65-67
X	X	line 61-62, 144-145,	X
line 78, 80	X	X	X
line 56-65	line 59-61	line 80-83, 100-110, 113-120, 126-128	line 81-82
line 34-38, 39/40, 46/47, 73-74	line 41-42, 78-82, 85-87	line 148-151, 158	line 13-15, 35, 36-41, 42-48, 51-52
line 66, 71-72, 83-84,	line 80-84	line 138-140, 147, 148-152, 158	line 35-36, 52-53, 54-57,
X	line 122-123	line 19-31, 169-175, 178-179, 194-196, 202-205, 219, 223,	line 21

PARTICIPANT 9	PARTICIPANT 10	PARTICIPANT 11
line 20	X	X
line 13-21, 67-69	X	X
X	X	line 37-40, 96-97, 106-109
line 56-59, 143-145	X	line 23-26
X	line 13-14, 101	line 32-36
line 145-147	line 28, 100-107	line 66-71
line 101-108, 115-117 (-), 128-132 (-)	, 32, 34-35,	line 36-37, 41-45, 49-50
X	line 141, 161	X
X	X	X
X	line 136-141, 162-165	X
line 32-34, 141-143, 154-155	line 63-65	line 83-89
line 27, 31, 34-38, 76, 149-152, 158-161	line 11-13, 51-53, 69-72, 75-80, 90-92, 143-148, 151-155, 167-168	line 94, 98-101, 111-112
line 55-56, 67, 156	X	line 26-33
line 52-56	line 94, 98	line 72-77, 88-91
X	line 20-25, 28, 89-93, 142-143	X
line 138-`40	line 168-170	line 91-93
line 135-138	like 62, 65-68	X
line 41-42, 66-67, 131-133	line 39-46(-), 118-121, 128-131	line 51-52, 54-57, 62-64
X	line 57	line 52-54, 57-59, 64-66
X	line 131-136	

Appendix N - Final coding matrix from eleven transcripts

THEME	SUBTHEME	_	_	PARTICIPANTS
_	_	PARTICIPANT 1	PARTICIPANT 2	PARTICIPANT 3
managing risk	risk to staff	line 59-64 & 69-71	line 86 & 203-205	X
_	risk to community	X	line 22-28, 30-35, 173 & 199	line 132 & 143-144
_	community integration	X	X	line 145-146
_	security measures	X	line 71-74, 176-180	X
_	calculated risk	line 91-93	line 58-61	X
_	risk paperwork	line 29-33	line 152-156	line 150-164
patient engagement	patient centred approach	line 50	line 180-185	line 53, 119-121, 129-130
_	interpersonal relationships	X	line 112, 187	line 16, 19, 175, 176-185, 194-197
_	informal therapy	X	X	line 127-129, 146-148, 176-180 184-186, 189-190
service developments	quantity of change	line 43	line 78, 80-89	X
_	attitudes to change	X	line 99-101, 203	X
development of job role	patient containment	line 39	line 20-22, 67, 71 & 103	line 18
_	job responsibilities	X	X	line 133-134, 150-151
_	terminology & language	X	X	line 44-48
ward environment	groups & therapies	line 47-49, 53-55 & 83-86	line 102, 111, 116-118, 126-135	line 101-108
_	routine & structure	X	X	X

PARTICIPANT 4	PARTICIPANT 5	PARTICIPANT 6
X	X	X
line 90-92	X	line 17-18
line 83-88	line 112	X
X	line 112	X
line 92-96, 98-111, 161-165	line 101-106	X
line 22-29, 134-136, 185-186, 196	line 92-100	line 106-111
X	line 30-32, 39-40, 86-87	line 35-39, 76-77, 87-90, 113-116, 121, 124-127, 129-135, 147-150
line 127, 129-133, 137-139, 141-143, 150, 183-185, 186-191	X	line 135-138
line 76-78, 129-134 192-195	X	line 116-118, 122-123, 138-143, 144-147
line 52-61, 64-68, 159	line 24/25, 56-65	line 26-27, 59-61, 135-138, 150-152
line 152-159, 179	line 22, 51-52, 78-80, 88	line 52-58, 61-63, 92-98, 152-156
line 90, 97	line 91, 111	X
line 22, 39-47, 197-198	line 50, 90-92,	line 99-106, 111-112, 152
line 24	X	X
Line 22, 29-30, 118-125	line 34-38, 39/40, 46/47, 73-74	line 41-42, 78-82, 85-87
X	line 66, 71-72, 83-84,	line 80-84

PARTICIPANT 7	**PARTICIPANT 8**	**PARTICIPANT 9**
line 35-37, 40-47, 108-110, 124-125, 128-134	X	line 20
X	line 60, 62-65	line 13-21, 67-69
line 31-34	X	X
line 267	X	line 56-59, 143-145
X	X	X
line 159-165, 206-207	line 67-70	line 145-147
line 68-74, 76-78, 85-86, 152-156, 161, 168-170, 179-184, 188-194, 205, 218-220,, 228-235	line 19-20, 27-33, 46-48, 53-54, 87, 90-91	line 101-108, 115-117 (-), 128-132 (-)
line 184-188, 207-209	X	X
line 19-31, 169-175, 178-179, 194-196, 202-205, 219, 223,	line 21, 70-74	X
line 80-83, 100-110, 113-120, 126-128	line 79-85	line 32-34, 135-138, 141-143, 154-155
line 78-80, 88-91	line 15, 85-86, 96-99	line 27, 31, 34-38, 76, 138-140, 149-152, 158-161
line 247-263m 267-269	line 94-95	line 55-56, 67, 156
line 145	line 21-22, 65-67	line 52-56
line 61-62, 144-145,	X	X
line 148-151, 158	line 13-15, 35, 36-41, 42-48, 51-52	line 41-42, 66-67, 131-133
line 138-140, 147, 148-152, 158	line 35-36, 52-53, 54-57,	X

PARTICIPANT 10	PARTICIPANT 11
X	X
X	X
X	line 37-40, 96-97, 106-109
X	line 23-26
line 13-14, 101	line 32-36
line 28, 100-107	line 66-71
, 32, 34-35,	line 36-37, 41-45, 49-50
line 141, 161	X
line 136-141, 162-165	X
line 63-65	line 83-89
line 11-13, 51-53, 69-72, 75-80, 90-92, 143-148, 151-155, 167-170	line 91-94, 98-101, 111-112
X	line 26-33
line 94, 98	line 72-77, 88-91
line 20-25, 28, 89-93, 142-143	X
line 39-46(-), 118-121, 128-131	line 51-52, 54-57, 62-64
line 57	line 52-54, 57-59, 64-66